THE IMPACT OF THE GLOBAL FUND PROGRAMMES ON HIV PREVENTION POLICY AND SERVICES IN UKRAINE IN 2003-2012

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Abstract

Ukraine is home to one of the world's fastest growing HIV epidemic and has received significant amounts of foreign aid to help it tackle the crisis. This study is an enquiry into the implementation of the Global Fund against AIDS, Tuberculosis and Malaria (GFATM) programmes in Ukraine, during the second decade of this country's post-Soviet economic and political transition. The discussion is positioned within a broader debate on aid effectiveness. By looking at the GFATM as an aid institution whose establishment was purported to improve the aid delivery process, the thesis offers a critical insight on the GFATM aid delivery model in the context of Ukraine.

The thesis investigates the conduct and practice of INGO and national NGOs in their role as Principal Recipients of GFATM grants targeting HIV prevention in Ukraine. Based on ethnographical enquiry conducted in three oblasts in Ukraine, and in capital Kyiv, the thesis aims to understand how NGOs have implemented HIV prevention services in context of state-owned health care system and to determine the perceived effects of the GF programmes on the ground. The thesis situates analysis of NGOs into a broader socio-political context of post-Soviet Ukraine and questions their role as central actors in delivering essential HIV programmes in parallel with or instead of the state, as well as the consequences for sustainability of such programmes. Using the particular experience in Ukraine, the thesis shows the influence of global funding institutions on relationships between state and civil society and altering of civil society's roles in aid programmes. The thesis includes a comprehensive literature analysis about the Global Fund and other donor programmes working in Ukraine in the area of HIV/AIDS.

Key words: Ukraine, the Global Fund, aid effectiveness, HIV prevention, HIV services, NGOs.

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My prayers and best wishes go to my compatriots, the people of Ukraine, who now are going through a very difficult time in their history. To them, and to the future of their children, I dedicate this work.

List of terms and abbreviations[1]

Activities - services the intervention provides to accomplish its objectives. Activities can be delivered through outreach, materials distribution, counselling sessions, workshops,etc.

Affected Communities, or Communities – communities of people living with or affected by HIV/AIDS, tuberculosis or malaria.

AIDS - Acquired immunodeficiency syndrome

AP- Associated Press

ART - Antiretroviral therapy or treatment

ARV - Antiretroviral drug

Bilateral Donor– the term used to describe a developed-country government (or its specialised agency) that provides official development assistance.

CCM - Country Coordinating Mechanism. A country-level partnership that includes representatives from government, multilateral and bilateral development partners, nongovernmental and faith-based organizations, affected communities, academic institutions and the private sector.

Coverage - The percentage of persons reached by activities/services.

CSO - civil society organisation. Associations of citizens (outside their families, friends and businesses) entered into voluntarily to advance their interests, ideas and ideologies.

DFID - Department for International Development (United Kingdom)

Disbursement – a periodic payment of grant funds to a Principal Recipient.

Donor– government, private business, foundation, or individual that makes contributions to the Global Fund.

DOTS - Directly Observed Treatment Short-Course (for tuberculosis)

EU – the European Union

Evaluation – a systematic collection of information about the activities, characteristics, and outcomes of programmes to make judgments about the programme, improve programme effectiveness, and/or inform decisions about future programming.

[1]Based on definitions provided by ICASO (n.d.), and some other sources

Framework Document – the founding document of the Global Fund, developed by the Transitional Working Group that worked to design the Global Fund in late 2000. The document codifies the organization's purpose, principles, scope and key processes.

FYE - Five-Year Evaluation of the Global Fund

FSU – Former Soviet Union countries – usually refers to all former Soviet republics minus the Baltic states, and includes Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan

GFATM - the Global Fund to Fight AIDS, Tuberculosis and Malaria

GF – same as above

GAVI - Global Alliance for Vaccines and Immunization

GNP+ - Global Network of People Living with HIV

Grant/grant agreement – a written agreement between the Global Fund and a PR that outlines the terms and conditions of Global Fund financing and the targets to be achieved. In most cases, the initial term lasts for two years (Phase 1), which can be extended for up to a further three years if the Board decides to commit additional resources for Phase 2.

HIV - Human immunodeficiency virus

HR – Harm reduction

HSS - Health systems strengthening

ICASO – International Council of AIDS Service Organisations

IEG - Independent Evaluation Group (at the World Bank)

Intervention - a specific set of activities implemented by a project or providers and can be focused at various levels such as the individual, small or large group, community or societal levels.

INGO – International nongovernmental organisation

IOM – International Organisation of Migration

LFA – the Local Fund Agent of the GF.A local, independent body contracted by the Global Fund to provide oversight of a PR on behalf of the GF.

MAP – Multi-country AIDS Program (World Bank)

MARPs – Most-at-Risk-Populations

MDGs – Millennium Development Goals

M&E – Monitoring and Evaluation

MOH – the Ministry of Health

MOU – Memorandum of understanding

Multilateral Organization– an institution that brings together multiple countries working in concert on a given issue, such as the United Nations, the World Bank, or WHO.

NAC - National AIDS Council – a multi-sectoral body of AIDS governance in Ukraine

National Strategy (or Plan) – document outlining country-specific priorities, goals and approaches for improving health and/or fighting AIDS, tuberculosis or malaria. A national strategy is typically developed by the national government (usually led by the Ministry of health or the national AIDS coordinating authority) but often involves other stakeholders.

NFM – The New Funding Model. A new model by which the GF distributes its funding that replaced the previous rounds-based system.

NGO - Nongovernmental organization

Oblast – the name of an administrative territory in Ukraine, similar to province

OECD – Organisation for Economic Co-operation and Development

OIG – Office of the Inspector General of the GF

PBF – Performance-based funding model of the GF: the allocation of resources based on the demonstration of performance.

PEPFAR - President's Emergency Plan for AIDS Relief (USA)

Portfolio – the collection of grants financed by the GF.

PLHIV - People Living with HIV

PLWHA – People Living with HIV/AIDS

PR (Principal Recipient) – the entity legally responsible for implementation and management of a grant, as set out in a grant agreement between the entity and the GF. PR receives disbursements from the GF, and either uses this money to implement programmatic activities directly and/or passes the funding on to Sub-recipients for them to use to implement.

Programme – generally refers to an overarching national or sub-national systematic response to the epidemic and includes a number of projects and interventions. A programme is usually time-bound.

Proposal – a written document that serves as the basis of an application for a GF grant and specifies, among other things, the beneficiaries, objectives, and activities to be supported by the funding requested.

'Quick' tests – a form of HIV screening which uses a finger blood specimen and produces a result in a few minutes. May also be called 'rapid' or 'express' test.

Replenishment – the forum in which, on a periodic basis (every two to three years), donors gather voluntarily to discuss the GF's progress and to voluntarily make multi-year pledges to the organization.

Rounds - the GF funding cycles, usually lasting for five years. A round consists of Phase 1 (first two years) after which the programme gets evaluated by the GF and a request for Phase 2 funding is made, approved at the condition that 'verifiable results' were achieved. Country may receive several grants, and round cycles often overlap. The rounds-based system is now being replaced by a New Funding Model (NFM).

SR - Sub-Recipient – an organization that receives GF funding through a PR to carry out activities that are part of a grant agreement.

Stop TB – Stop Tuberculosis Partnership (a global partnership program)

TB - Tuberculosis

UNAIDS - Joint United Nations Program on HIV/AIDS

UNICEF - United Nations Children's Fund

UNDP - United Nations Development Programme

UNODC – United Nations Office of Drug Control

USSR – the Union of Soviet Socialist Republics

USAID - United States Agency for International Development

WHO - World Health Organization

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CHAPTER 1. DILEMMAS OF AID. THE GLOBAL HEALTH TRANSIT: FROM SHARED VALUES TO DISEASE-CENTRED PARTNERSHIPS. THE RATIONALE FOR STUDYING THE GLOBAL FUND.

Introduction

This study is an enquiry into the implementation of the Global Fund against AIDS, Tuberculosis and Malaria (GFATM)[2] programmes in Ukraine, during the second decade of this country's post-Soviet economic and political transition. GFATM is an aid institution – "the main multilateral funder in global health" (GFATM, n.d.) that provides aid to countries to fight their HIV/AIDS, tuberculosis and malaria epidemics.

The main argument of the thesis is that the core models promoted by GF, such as service delivery by NGOs, performance-based funding, and governance by a country coordinating mechanism were used opportunistically by Principal Recipients in Ukraine in delivering HIV services parallel with or instead of the state, which had a profound impact on sustainability of HIV prevention, on relationships between state and civil society and on governance of the GF programmes. The thesis draws on the author's 15 years of extensive experience with HIV/AIDS programme implementation, as well as with aid programmes in post-Soviet NGO sector in Ukraine, Russia and other FSU states. The author's background was important in choosing a research approach, which was determined as an ethnographic enquiry. The advantage of ethnography, taking into account the author's familiarity and experience with aid organisations, was seen, following Hammersley (1985,p. 152) in enabling the researcher to treat the "familiar social settings" to be studied "as anthropologically strange" in which the task for the researcher was "to document the culture – the perspective and practices – of the people in these settings".

Chapter 1 sets a general thematic background for the present study, whose subject positions it within the framework of the aid effectiveness debate. It discusses

[2] Throughout this thesis, the terms "Global Fund", "GF" and "GFATM" are used interchangeably.

the evolution of global health institutions, describes the establishment of the GF and its framework principles and core models.

Chapter 2 describes the country context of Ukraine in regard to its post-Soviet transformations, health systems, HIV epidemic and the entry of the GF.

Chapter 3 addresses the methodological framework for the present research, reviews the key literature, document sources and other data used in writing the thesis.

Chapter 4 summarises findings on the specificity of NGO implementation in the context of state HIV health care, including referral and linkage to services; target setting; and the perceived roles and relations of PR NGOs with other NGOs in Ukraine.

Chapter 5 offers insight into the conduct of NGOs delivering HIV prevention services, and describes monitoring and reporting systems and practices used by PRs.

Chapter 6 discusses the governance of GF programmes embodied in the Country Coordinating Mechanism (CCM) as perceived by study participants.

Chapter 7 further develops the discussion and outlines the key arguments that this research made.

The Conclusion outlines the implications of the aftermath of the GF programmes for future of HIV prevention services if the GF exits from Ukraine.

1.1 The aid debate and its ramifications

> … years after the fall of the Berlin Wall, there is just one major area of the world in which central planning is still seen as a way to achieve prosperity – countries that receive foreign aid.
> Planners versus searchers in foreign aid (Easterly 2006)

This thesis is positioned within the broad topic of aid effectiveness, which inspired me to undertake this study. The section below will present some of the key events and arguments of the aid effectiveness debate. Establishing the ramifications

of the aid debate was important to situate the later discussion on the GF and to enable conceptualising about what was happening to the GF aid delivery model in Ukraine.

Development aid and its effectiveness have not always been subjects of debate. In the post-World War II (WWII) institutional environment, it seemed easy to make the case for development aid. Developed countries could help non-developed countries at a negligible cost if they allocated a very small percentage of their GDPs to this task. Several decades after WWII, the idyllic picture of foreign aid "started to pale" (Prokopijevic 2006, p. 3), as strong criticisms began to be voiced by scholars and policy makers alike. These criticisms initiated the foreign aid debate. Although a comprehensive review of the "massive outpouring of studies on the effectiveness of foreign aid" (Hansen and Tarp 2000, p.375) is not feasible here, I shall present those characteristics of the debate, most relevant to my research below.

In the early 1970s, Peter Bauer, a development economist, and "a persistent and articulate critic of foreign aid" (Shleifer 2009, p. 379), formulated his position on aid that he saw as not only failing to speed up, but actually hurting economic development. Bauer defined foreign aid as "a transfer of resources from the taxpayer of a donor country to the government of a recipient country" (Bauer 1975, p. 396).

Williamson (2009) described the environment in which aid agencies operate as hindering their ability to succeed. Comparing the aid delivery business to Soviet-style central planning, with its huge bureaucracy, she suggests that aid delivery problems stem from such issues as negligible feedback from beneficiaries, hard to observe impacts, and the low probability of bureaucratic effort. Prokopijevich (2006, p.19) lambasts aid agencies' monitoring and evaluation systems by comparing them to Communist centralized planning that "never conceded that their five year-plans had failed" and referring to monitoring as "mass deception through reporting and evaluation". Another prominent critic, William Easterly says aid bureaucracies organize themselves "as a cartel of good intentions, suppressing critical feedback and learning from the past, suppressing competitive pressure to deliver results, and suppressing identification of the best channel of resources for different objectives " (Easterly 2003, p. 34). Other authors similarly critique the 'aid fiasco' (Moyo 2009; Lal 1996). Studies highlighting how foreign aid fails and giving possible

explanations as to why, were produced by Svensson (2000), Knack (2001), Williamson (2009) and others.

The above criticisms charge that aid enlarges government bureaucracies in donor countries and perpetuates bad governments in beneficiary countries, thereby enriching elites. In these researchers' eyes, aid programs should be dramatically reformed, substantially curtailed, or eliminated altogether (Radelet 2006).

Supporters counter that these arguments are overstated. After the publication of Bauer's *Dissent on Development*, staunch criticism of his approach was given by Nicholas Stern who called the book "not a valuable contribution to the study of development" (Stern 1974, p. 209). Stern gave the following case for aid: people in rich countries are much richer than people in the poor ones, and therefore foreign aid is their moral obligation (Shleifer 2009). Hansen and Tarp (2000, p. 376) noted the lack of a "strong analytical framework ... to compare and evaluate the causal relationships" in aid effectiveness studies.

One of the key advocates of aid effectiveness is Jeffrey Sachs, Columbia University professor and director of The Earth Institute. Sachs supports the broad goal of foreign aid as embodied in the United Nations Millennium Development Goals (MDGs), of which he is believed to be the main author (Prokopijevic 2006). He was appointed a Special Adviser on MDGs by former UN Secretary-General Kofi Annan, and continues in the post under current UN Secretary General Ban Ki-Moon. The MDGs were criticised for not creating any positive incentives for any actors, and for promising results that are beyond the actors' control to achieve (Easterly 2006). Nevertheless, in his 2005 book *The End of Poverty: Economic Possibilities for Our Time*, Sachs asserted that poverty can be eliminated globally by the year 2025 through carefully planned development aid and called for a doubling of worldwide aid flows which he viewed as a moral obligation of rich countries that will send forth 'mighty currents of hope' (Sachs 2005). First known in Western development circles for his role in the 1990s as an architect of the neo-liberal[3] "transition from communism to capitalism" (Nee, 2010) in Eastern Europe, Sachs and the *garvardskie*

[3] 'Neo-liberalism represents a set of ideas that emerged from the mid to late 1970s, and are famously associated with the economic policies introduced by Margaret Thatcher in the UK and Ronald Reagan in the U.S. (Jones et al 2005) Neo-liberalism advocates support for great economic liberalization, privatization, free trade, open markets, deregulation, and cuts in government spending.

malchiki (‘Harvard boys’) with whom he worked on the U.S.-funded aid programme he managed [4] are associated by many in the region with the pauperization of populations in Russia and Ukraine.

The arguments presented above have been standing at the core of the foreign aid debate over the last 40 years.

1.1.1 Aid should be effective: the emergence of the Paris Declaration

In the analyses of aid effectiveness, the motivations and incentives faced by all involved are often overlooked or assumed to be benevolent. In many cases, it is presumed that these individuals put aside their own interests and act in the best interest of the developing countries.[5] Williamson attributes this position to Jeffrey Sachs. She further suggests that this line of reasoning assumes that donor countries or aid agencies are unbiased in their initial decision to donate to a specific country (Williamson 2009). Furthermore, it presumes that recipient governments allocate foreign aid in an effective manner in order to accomplish the required tasks. However, these assumptions are often called into question. As Svennson (2000) has argued, the decision-making process surrounding aid disbursement is burdened with different stakeholders, special interests, and ‘rent-seeking’.

Over the past ten years, the international community has increasingly focused on ways to better coordinate development aid. This culminated in the Paris Declaration on Aid Effectiveness, “a first attempt to tackle international policy coordination problems in the field of development aid” (Severino and Ray 2010, p. 19). Adopted in March 2005 by more than 100 countries and organisations, the Paris

[4] Headed by Sachs, USAID-funded project of the Harvard Institute for International Development promoted ‘shock therapy’ and a voucher privatization programme in Russia and later in Ukraine that resulted in a rapid transfer of state-owned assets to few private hands - “the Great Grab” (Wedel 2001, p. 138). For most ex-Soviet citizens, it meant a complete economic disenfranchising, and for some, extreme poverty. Intended to spread the fruits of the free market, voucher privatization, advocated by Sachs and advisors, was “a *de facto* fraud” (Millar 1996) that helped to create a system of “tycoon capitalism” in Russia, Ukraine and other post-Soviet states.

[5] The use of terms such as ‘developing countries,’ the ‘Third World’ in this thesis is for convenience sake only since it represents a language used by international aid organizations, including the Global Fund, and does not imply that all countries are following similar development or that others have reached a higher or final stage of development.

Declaration set commitments and measurable targets to which both donors and recipients agreed. Five central pillars of making aid effective were articulated:

- ownership (countries should exercise leadership in setting their own development priorities)
- alignment (donors to base their support on countries' national development strategies, institutions, and procedures)
- harmonisation (donors using common, simplified, and more transparent arrangements and procedures, and better dividing labour)
- managing for results (measuring results against targets)
- mutual accountability (evaluating effectiveness based on these results). (Paris Declaration 2005)

The Paris Declaration was viewed as a key instrument for increasing aid coordination. The signatories of the Paris Declaration pledged to work toward indicators to harmonize, align, and more efficiently manage aid efforts (Schneider and Garrett 2009). Another important framework for aid coordination was the Accra Agenda for Action (AAA) -- signed in 2008 at the 3rd High Level Forum on Aid Effectiveness. AAA built on the commitments of the Paris Declaration and set out four further key aid principles: 1) conditionality, 2) country systems, 3) predictability, and 4) untying aid.

The results to date for the Paris Declaration are mixed (Schneider and Garrett 2009). Development Assistance Committee (DAC), the key forum on donor aid information sharing, was set by the Organization for Economic Cooperation and Development's (OECD) to produce annual reports on official development assistance (ODA)(OECD, n.d.). However, because the only enforcement mechanism for assuring achievement of the harmonization and alignment targets is "moral suasion", reports produced by OECD offer "few real rays of hope" (Schneider and Garrett 2009, p. 10) in terms of donors' accountability.

1.1.2 No-coordination?

In November 2011, the Fourth High Level Forum held in Busan, Korea, following some of the Paris Declaration monitoring surveys, indicated that neither

the U.S. – a major world donor – nor other donors came close to meeting the targets on harmonization or many other aspects of aid effectiveness they had set for themselves (Lawson 2013).

Santiso and Frot (2010) noted that the increase in the number of actors on the aid stage had shaped the way aid was disbursed, and argued that a growing aid fragmentation was drawing on administrative and human resources of the recipient countries, while carrying little money. As an example, Santiso and Frot noted that in 2007, sectors in some recipient countries attracted more than 2,000 simultaneous aid projects, of which the most fragmented was the social sector. Djankov et al. (2009) found that the presence of multiple donors in a given country rendered aid less effective. Knack (2001) found that higher levels of aid erode the quality of governance.

Not all working in foreign aid are concerned about the growing number of donors in recipient countries and even view no-coordination as beneficial. Lawson (2013) contends that the wide variety of independent donors is valuable for demonstrating pluralism in action and reflecting the decentralization of authority that many development plans promote. Others argue that having a range of active donors leads to more ideas, competition, and innovation (Santiso and Frot,2010).

1.1.3 The adjustment of aid institutions to the 'language of failure'

The 'language of failure' did not go unnoticed. As the criticisms of aid delivery began to accumulate from the 1970s on, the aid community did not disregard this evidence of failure. Neither did it conclude that foreign aid was a bad idea, as noted by Shleifer (2009). Rather, he suggests, the conceptual framework for foreign aid has *adjusted to the failure*, developing three rationales to explain for the lack of consistent results:

(1) The first answer to the failure of aid was to spend more, not less. Proponents of this strategy claimed that insufficient spending was the reason why aid was not generating the anticipated benefits.

(2) The focus of foreign aid goals shifted from assisting the economic growth to poverty alleviation. Aid should become a massive welfare program for the developing world, which offered the distinct advantage of lower accountability for the donors.

(3) Finally, efforts to lobby support for continuing and increasing aid spending shifted away from attempts to prove aid effectiveness. Instead, aid advocates began courting the sympathy of Western taxpayers and the political establishment, making public relations increasingly the cornerstone of foreign aid (Shleifer 2009).

In this regard, one of the trends in aid delivery is to blame the recipient for its failure. Because in most countries, the recipients are national governments, they get blamed for being lazy, inactive, disinterested, corrupt, and lacking the appropriate institutions or understanding of the aid objectives. The 'blame the government' narrative is particularly used when aid implementers are non-governmental: if results are successful, it is usually to their credit, if they are not, it's because of a 'bad government'. Although the 'bad government' description "frequently fits into the situation" (Prokopijevic 2006, p.17), it is ultimately the donors' own choice whether or not to enter the target country with aid. If not enough information was considered, including on the risks of implementing in a particular country, that should be their failure rather than that of the recipient. Prokopijevic attributes the prevailing view of donors as 'good' and recipients as being 'at fault' to the international media, and notes that all important decisions and instruments [in regard to information dissemination] are in the hands of donors.

A potential remedy to address presumed deficits of 'bad government' in aid delivery was suggested in Paul Collier's book *The Bottom Billion* (2007), a "long-sought middle way between the critics and the cheerleaders of foreign aid" (Easterly 2007, p. 1475). As an alternative aid delivery model, Collier suggests "Independent Service Authorities" (ISAs) - organisations, independent from the government, that co-opt civil society to manage aid and public money and incorporate the scrutiny of public opinion and NGOs to determine how to maximize output from the expenditure of this money. Having himself acknowledged later that donor support for NGOs was

not "backed by adequate evaluation of their performance: they are, in effect, unaccountable," Collier and colleagues admitted that this model needed to be "tailored to the distinctive needs of fragile states" (Bold, Collier and Zeitlin 2009, p.2). Although widely acclaimed, Collier's book has also been criticised for its lack of historical and contextual analysis of states 'at the bottom billion', and for failing to show "the complicity of Western powers in the trap of the 'curse of resources'" (Hoebink 2008, p. 735), while the use of military intervention to reduce conflict and guarantee democracy was deemed as the most controversial proposal in Collier's book by Segal (2008) and others.

1.2 The case of aid to the former Soviet bloc

It may seem easy to make the case for foreign aid in the post-Communist world. The collapse of communism in Eastern Europe resulted in promised Western aid in the billions of dollars. The peoples of the countries that liberated themselves from the Communist regimes in 1989 in East and Central Europe, and in 1991 in the former Soviet Union (FSU) needed help in building their economies, political systems, and societies to quickly join the family of world nations and continue living happily ever after. Despite the fact that pro-democracy movements emerged earlier in Eastern Europe than in the FSU, the political momentum for change was ripe in all parts of that world. Local populations believed that political change was necessary, and people wanted to live in established, democratically-run states with well-functioning economies. In terms of their political importance, and their proclaimed goals, Western aid programmes were much welcomed in all post-Communist countries. But in channelling the aid the donors encountered complex systems of patronage and social relations (Bruno 1998; Wedel 2001). Several key features distinguished the delivery of aid in the FSU states.

- *The shift from an aid giver to aid taker*

The Soviet Union was a great source of aid (Carothers 1999b). Aid programmes sponsored by the USSR were common in parts of Africa, the Middle East, Asia, and Latin America. The sudden status of post-communist states in the

1990s as recipients of Western aid was a profound reversal of their self-image as aid givers. There was no institutional background/infrastructure for absorbing the large influx of aid. While this shift was mainly ideological, FSU countries' prior ability to deliver aid, including at the UN level, surely meant that they were able to determine their own goals and priorities. However, there is no evidence that Western donors ever attempted to utilise their expertise.

- *Strategic approaches to aid delivery*

Carothers (1999b) distinguished two important approaches to aid delivery to civil society organizations in post-communist countries. The first viewed aid delivery as a continuation of the ideological battles of the Cold War, and promoted anticommunist groups and anticommunist agendas, as well as was excluding anyone with a politically tainted past. This approach seemed more appropriate in Eastern Europe, where power transitioned from the old communist elites to newly emerged democrats. Carothers noted that the anticommunist agenda could not be promoted effectively in the FSU region where none of the new political elites were completely disengaged from the communist connection and therefore "true change became more difficult because the legacies of communism tended to be more entrenched the farther east the donors went" (Wedel 2001, p. 206). With the principal objective of Western organisations to ensure that communism could not return to the FSU region, aid agencies dedicated themselves to "demolishing the state structures of the Soviet era" as quickly as possible and without viable alternatives (ibid., p. 173). Particularly in Ukraine, 'democracy promotion' and support for NGOs bypassing the state was a consistent feature of aid programmes, as discussed in Chapter 2. Among the criticisms of the 'democracy promotion' model was that, by promoting a very specific and idealized notion of democracy, arising mainly from the Western perspective, it tended to support a one-size-fits-all approach, paid little attention to local contexts, and frequently treated "the symptoms rather than the causes of democratic deficits" (Carothers 1999b, p. 101).

The second feature of aid agencies in the FSU lay in adhering to their 'Third World' experience: "Although in theory, donors recognized the distinctiveness of Central and Eastern Europe, the point of reference for many aid providers was their

Third World experience" (Wedel 2001, p.38-39). This meant the transposition of entire bureaucratic structures, strategies, systems, and, in many cases, the actual personnel of traditional foreign aid programmes, to a completely new post-communist landscape. The essence of this approach is described by Carothers (1999b) as 'the external project' method, a traditional aid approach in which an external organisation runs all aspects of implementation work, uses external consultants to assess the needs of the recipient country and designs the projects to meet those needs. In the FSU, the 'external project' approach became the predominant form of aid delivery. It tended to restrict funding to fairly narrow groups, typically "intellectual elites concentrated in capital cities" (Hann 1998, p. xiii). As I argue in Chapter 2, this often led to sidelining *bona fide* grass roots organisations and implanting 'transnational advocates' – international NGOs with pre-set external agendas. In regard to the Global Fund, whose programmes in Ukraine were managed by an international NGO (INGO) and its linking organisations, the new and multiple relationships appeared in health services, HIV prevention organisation and within civil society. The need to identify and analyse the outcomes of these programmes prompted the development of my research.

An important aspect of the project mentality is the planned character of aid delivery – 'central planning mentality' - in which "the answer to the tragedies of poverty is a large bureaucratic apparatus to dictate quantities of different development goods and services" (Easterly 2006, p. 1). The terminology of 'planning' was a "conventional wisdom in the development community" (Friedman and Sowell 2005, p.443). Western donors seemed unaware of the ironies involved in delivering aid using 'central planning' methods in FSU countries that were originally based on central planning. In doing this, they were to "follow in Communism's footsteps" (Wedel 2001, p. 165) and encounter old Soviet-era legacies and work practices that, in particular, appeared in the way GF programmes were run on the ground, discussed in more detail in Chapters 4 and 5 that analyse the GF programme delivery by NGOs in Ukraine.

1.3 The rationale for studying the Global Fund

The establishment of the GF can be viewed both as a response to aid critics and a reflection of its backers' belief that a new approach was needed, one that could operate more effectively than existing bilateral and multilateral aid mechanisms (Wigell 2008). Among the criticisms of foreign aid that the establishment of the GF was intended to change were:

- Aid programs are inefficient, with large bureaucracies imposing high administrative costs on recipients (Easterly 2003).
- Aid is misallocated. Too much aid is directed toward countries that either are not the poorest or do not have policies conducive to using aid effectively (Burnside and Dollar 2000; Collier and Dollar 2002).
- Donors do not sufficiently involve recipients in program design, and earmark significant funds for their own priorities, leading to a lack of local ownership of aid programs.
- Donor activities are not well coordinated or harmonised, with multiple donors financing similar projects with differing design, implementation, monitoring and evaluation systems, which leads to duplication, and less effective aid.
- Donors do not adapt their approach to differing circumstances on the ground in recipient countries, relying on a one-size-fits-all approach for all recipients, regardless of the quality of their governance and commitment to strong development policies (Radelet 2004).
- Donors do not build institutional capacity in recipient countries, and instead often bypass local institutions and try to substitute for them, which undermines institutional capacity and retards development.
- Incentives are badly skewed. Donors focus on providing inputs rather than on achieving specified development outcomes and their staffs are rewarded accordingly.
- Monitoring and evaluation systems are deeply flawed. Baseline data are rarely recorded and indicators for progress are badly chosen, so there is little systematic information about what works and what does not.

The G8 Genoa Summit Communiqué in 2001 that confirmed the establishment of the GF, outlined specifically how a new Fund would work differently:

> The Fund will promote an *integrated approach emphasising prevention in a continuum of treatment and care*… operate according to principles of *proven scientific and medical effectiveness, rapid resource transfer, low transaction costs,* and *light governance* with a strong *focus on outcomes*… the existence of the Fund will promote *improved co-ordination among donors* and provide further incentives for private sector research and development…The engagement of developing countries in the purpose and operation of the Fund will be crucial to *ensure ownership* and commitment to results. *Local partners,* including NGOs, and international agencies, *will be instrumental* in the successful operation of the Fund.(G8 Genoa 2001) [emphasis added]

The research presented herein may be viewed as an extension into the studies about aid delivery and its effectiveness, using the particular experience of the Global Fund programmes in Ukraine. It sought to examine how the GF aid delivery model, as a new promised form of aid delivery, manifested itself on the ground in Ukraine.

1.3.1 Dilemmas of studying aid programmes: the need for a 'critical space'.

At the beginning of this chapter, a number of factors that led to a questioning of the effectiveness of aid have been discussed. Studying concrete effects of aid programmes, however, presents a researcher with several dilemmas.

The first, 'external' dilemma, appears in international context, in which donors, being powerful decision makers, exert significant influence on aid research, its design, scope and methods. As Habicht et al (1999, p.16) noted, variability of standards of certainty required by decision makers in judging the effectiveness of [aid] interventions poses "a major barrier to rational public policy". Among the issues of concern associated with donor-led evaluations are: different ways how donor agreements may guide evaluation into certain (and rigid) criteria, a perceived neutrality of donor-led evaluations, and power inequalities arising in the context of research that may result in a lack of voice for all those engaged in aid delivery. An example of how research into aid implementation became a challenge for the researchers, is presented in a text Box 1 below, as described by Walt et al. (2008, p.311):

Box 1. Applying health policy analysis in a fast moving policy environment

Brugha et al. (2002, 2004) have conducted a number of studies on global health initiatives such as the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Designed to gather and report the views of national-level stakeholders at very early stages in their implementation, the studies were sensitive. For the Global Fund, in particular, the research was perceived as premature, enabling country stakeholders to articulate criticisms, which it feared would have a deleterious effect on the need to raise significantly greater funds globally. The Global Fund Secretariat in Geneva requested that the scope of the study be widened to report its perspective, which was beyond the capacity and resources available to the researchers. In both studies, under pressure from funding agencies, the researchers reported findings within 9 months. The researchers resisted pressure from the Global Fund Secretariat to report interim findings to the Fund in late 2003, in advance of reporting back to country stakeholders.

The policy environment was very fluid, and the researchers found they were tracking a moving target — one where the Global Fund itself was responding to difficulties, changing guidelines, and proving to be a 'learning organization'. Despite what the researchers viewed as rapid feedback of findings, given the need for rigour, the study funders and the Global Fund responded that the findings only confirmed what they had already learned through their own channels; and that these findings were being superseded by events.

The dynamic nature of the policy environment made data collection and analysis difficult, and created sensitivities between the global initiatives, research funders and the researchers. One lesson was that maintaining a balance between independence and engagement with the entity being studied is difficult but key; building trust is essential if findings are to be taken on board.

The second, 'internal' dilemma, appears at the country level. While the context of aid delivery is widely and grossly different in different countries, as Riddell (2009) points out, there is usually little attempt to find out whether most aid works or not in particular countries or settings. This task is far from easy. With various vested interest groups operating in countries around the aid programmes, often not easily recognisable by an outside observer, the aid research may also be guided or distorted by powerful in-country stakeholders.

Because of an often partisan nature of the aid discourse, creating a research environment for conducting an independent study of aid is a task far from easy. To look into donor-funded activities and study the aid delivery processes, the need is crucial to create a research environment that would allow including a broader scope

of views to be reflected, including those that may not necessarily be positive accounts.

In this regard, I felt an acute need to set a 'critical space' that could allow for more critical voices to be heard in order to capture more fully the voices of all with a stake in the aid delivery process and to construct a broader and more representative picture of how the aid delivery works on the ground. Creating a 'critical space' for my research was necessary in order to question, following Easterly and Williamson, whether the aid agencies [in this case, the GF] performed the way they say they should – the question was named by the latter authors as "the key one in the aid effectiveness debate" (Easterly and Williamson, n.d., p. 6). The methodology and a chosen research approach are described in more detail in Chapter 3.

The need for a 'critical space' was also apparent given the typical GF and its Principal Recipients' narratives about Ukraine as a "success story" of HIV/AIDS programmes (International HIV/AIDS Alliance 2012, p. 10). This narrative was persisting despite the history of being the first ever country whose grant was suspended by the GF, and applied to the 'after-suspension' context to describe the GF programme implementation by an INGO/NGOs. The 'success' narrative in Ukraine has been utilized by PRs to assert the GF principle of civil society engagement in aid delivery (an example of a GF-funded 'success story' publication is provided in Appendix F), while the 'blame the government' and 'weak and corrupt government' rhetoric has been applied to Ukraine's state and its health services. As Prokopijevich (2006) suggested, the latter rhetoric is usually utilised by donors in cases of aid failure.

The narrative juxtaposing state and non-governmental programmes referring to the Government of Ukraine as weak, corrupt, and ineffective, in contrast to 'well-established INGOs', remained a characteristic feature of GF communications, as well as of the other donors. For example, in 2008, the head of the UNAIDS mission presenting results of its evaluation to stakeholders in Kyiv, said:

> The Global Fund grant programmes clearly specify targets, and how prevention programmes will be implemented and monitored. The workplans for the GF programmes represent a clearer and more useful framework for the

national prevention programme than does the national AIDS programme of the Government (UNAIDS, 2008).

Zhukova (2013) defined the GF discourse in Ukraine as "transnational biopolitics" and argued that juxtaposition to the state aimed to create "the image of an international goodness in saving lives in a post-Soviet region as opposed to the image of the impotent post-Soviet state which put those lives at risk, not being able to protect them in the face of the epidemic" (Zhukova 2013, p. 249).

1.3.2 Research question and aims of the research

To enable a critical prism to look closer at the GF programmes delivery on the ground in Ukraine, the preferred research approach for my study was chosen to be an ethnographic enquiry.

This research addresses the following key Research Question:

How have the programmes funded by the Global Fund promoted its service delivery and governance models, and what was their impact on HIV prevention policies, services and governance systems in Ukraine?

Aims of the research

This inquiry critically examines the Global Fund aid delivery model and its effects on the delivery of HIV prevention services in Ukraine during Rounds 1 and 6 of GF grants (2003-2012) as they were perceived 'on the ground' by aid delivery participants.

These two Rounds were chosen for the following reasons:

- Round 1 suspension to Ukraine was the first suspension in the GF history and received a great deal of international attention[6]. Despite this, there has been no significant research into the aftermath of the suspension and the grant transfer to an international NGO.
- Rounds 1 and 6 (R1-R6) covered the period when GF funding to Ukraine and the EECA region was at its highest. During this time, important interventions and policies were practiced.

[6] More details on how the GF suspended Ukraine's Round 1 grant in 2004 are provided in Chapter 2.

Guided by the research aim, the current study fulfilled the following objectives:

- Critically reviewed the evidence available, using the delivery of HIV prevention services as an example, on how the GF performance-based model manifested itself in target setting and monitoring practices, referrals between NGO-run settings and state health care, and in other aspects of GF-funded HIV services.
- Analysed the roles and relationships that appeared between Principal Recipient NGO(s) and other state and non-state stakeholders when they acted as GF implementers;
- Analysed how the GF country governance model - the Country Coordinating Mechanism (CCM) – manifested itself in Ukraine through country-run processes and structures.

In Conclusion, the research makes recommendations to improve the effectiveness of HIV prevention in Ukraine.

1.4 Global health policies and governance before the Global Fund.

The section below offers insights of the debate on the Global Fund by presenting an overview of the development in international health policy institutions over time. Taking the 1948 creation of the World Health Organization (WHO) as a point of departure, I shall present an overview of international health policy institutions, describing the political context of each period, in which the dominant actors, key publications and events are identified, that preceded the establishment of the GF.

1.4.1 Post WWII: the 'shared values' era in global health

The end of WWII brought about a tremendous rise of global governance institutions, including, primarily, the United Nations (UN). As the Allies were winning the war against Nazi Germany, the UN Conference on International Organization was convened in April 1945 in San Francisco. It resulted in the creation of the UN Charter (Moore and Pubantz 2006), which was ratified by most nations by October 1945.

Savedoff (2012) distinguishes two paradigms for international cooperation: 'global government' and 'mixed coalition'. He describes a global government paradigm as a form of cooperation that models its organisations, procedures, and actions on the typical form of a modern nation-state. The logic of such an approach is to use the authority and legitimacy of government to establish rules and actions that are binding for member states. The UN system was an institution created under this paradigm, along with such later organizations as the European Union (EU). The global government paradigm presupposes fixed membership of nation-states for a wide range of activities to be carried out by international institutions. The result is a set of laws and institutions that are binding for all members and are exercised by signing international conventions and declarations with their subsequent ratification by member countries.

A 'mixed-coalition' paradigm represents a more fluid approach than that of global government. It assembles interested parties — which may include nation-states, private foundations, for-profit firms, and civil society groups — around specific initiatives that may or may not result in the establishment of formal organizations. This approach works opportunistically — members take action that ultimately, they hope, will demonstrate success and gain broader international adherence. An example of a mixed coalition initiative is the Global Fund against AIDS, Tuberculosis and Malaria (Savedoff 2012).

In the second part of the 20th century, Savedoff (2012) argues, the 'global government' paradigm prevailed in international relations. He attributes this to the fact that, despite ideological divisions separating the Soviet bloc from the Western countries, the idea of the social-welfare state was more widely shared. Harvey (2005) defined the role of the welfare state as focusing on full employment, economic growth, and the welfare of its citizens, where the state power should be freely deployed, and, if necessary, intervening in or even substituting for market processes to achieve these ends. In the post-WWII era, the rise of global health institutions reflected the era of shared values on social welfare.

1.4.2 The rise and eclipse of the WHO

The World Health Organization (WHO) was among the new institutions for global governance with a long history of advocating for equity in health (Ewig 2010) and most of the foundations of modern international health policy were established during this era of shared values on health care. But, in the divided Cold War world, health care often became "the vehicle for a political and ideological battle" (WHO 2008).

The WHO was "a hybrid institution" with diplomatic and political structures, whose governance structure was problematic from the start (Savedoff 2012, p. 6). First, in 1948, the US delayed ratification of the WHO constitution. Despite a general agreement about WHO's role in improving health care for the poor, shared by the USSR, Scandinavian nations and several other European states, the US vehemently opposed WHO's alleged involvement in what was referred to as "socialist' medicine" (Siddiqi 1995, p. 102). A compromise was found that allowed the US to ratify the WHO constitution, which included limiting the WHO's role in social care issues to fact-finding, analysis and collaboration with other agencies (Siddiqi 1995). The US Congress ratified the WHO constitution with reservations that it would not commit the US to enact any specific legislative program (American Journal of International Law 1950). The issue of accessible health care has remained problematic in the US until the present day[7].

In 1949, the WHO suffered a blow when the Soviet Union withdrew its membership on the grounds that "the direction the organization has taken did not correspond to the tasks which were set in 1946 at the inaugural conference"(Siddiqi 1995, p. 103). The move was followed by other socialist member states who complained about WHO not contributing enough in vaccines, antibiotics, drugs and research to countries that suffered under German occupation, and also that WHO was falling under American domination. Andrey Gromyko, the Soviet Deputy Foreign Minister at the time, called the WHO 'useless' (Siddiqi 1995).

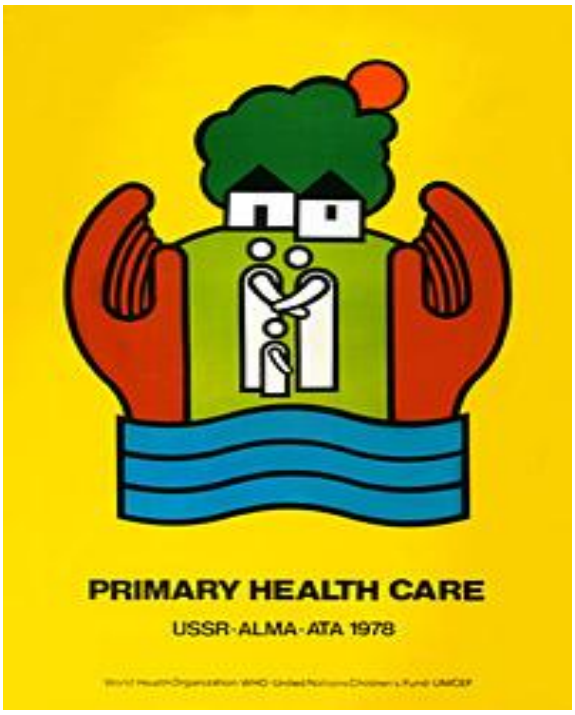
[7] In 1993, the attempt to reform the US health-care was made by a Democratic U.S. President Bill Clinton who introduced a 'Health Security Act', a comprehensive plan to provide universal health care for all Americans. The plan faced fierce opposition from conservatives and the powerful health insurance industry, as well as competing vested interests within the Democratic Party, and was not successful. Political battles resumed over current U.S. President Obama's *Patient Protection and Affordable Care Act*, including an infamous U.S. Government shutdown in October 2013 aimed at blocking Obamacare from being funded (Galston 2013).

Stalin's death in 1953 signified the end of the USSR's isolationist foreign policy and the country's return to the international arena. The USSR returned to full WHO membership in 1957. Numerous new, post-colonial member states also joined, serving to dilute the influence of the Western countries (Siddiqi 1995), while the Soviet Union viewed the WHO as "a platform from which to demonstrate the superiority of Soviet socialist medicine" (Osakwe 1972, p. 125), and it was also training cadres for new post-colonial states by educating many African students in Soviet medical institutes.

Around this time, the US President Dwight Eisenhower formulated the need to provide funding for international health in his Special Message to the U.S. Congress:

> For half of mankind, disease and disability are a normal condition of life. This incalculable burden not only causes poverty and distress, and impedes economic development, but provides a fertile field for the spread of communism.(Eisenhower 1955)

As the collective voting power of Second and Third World countries was increasing, disparities grew between voting strength and the financial contributions of WHO member states. The emergence of the *Geneva Group* (states that paid a majority of contributions) and the *Group of 77* (representing interests of developing countries) marked the divide (Savedoff 2012), while globally, the emergence of the Non-Aligned Movement (NAM) – a major attempt "to thwart the Cold War" (Subedi 1996, p. 169) - symbolized a new, 'Southern' vision of world order.



A major effort to consolidate international health policy was made at the landmark Alma Ata Health Conference in 1978 (see logo). Convened by the WHO and the

United Nations Children's Fund (UNICEF), and hosted by the USSR, the Alma Ata conference drew representatives from 134 countries, 67 international organisations, and many NGOs and resulted in the adoption of the Alma Ata Declaration of Health. Section One of the Declaration defined "health as a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal"(WHO 1978). Section Three of the Declaration emphasised the role of the state in providing adequate health and social measures, and enunciated the "Health for All by the Year 2000" call for the attainment by all peoples of the world of primary health care "based on practical, scientifically sound and socially acceptable methods and technology made universally accessible" (Gillam 2008, p.536).

Soon after the endorsement of the Alma Ata Declaration, the Primary Health Care (PHC) model came under attack from politicians and aid experts in developed countries who could accept neither the core PHC principle that communities in developing countries would be responsible for planning and implementing their own healthcare services (Hall and Taylor 2003), nor the PHC model, considered too broad and idealistic to be implemented widely. An article published in the *New England Journal of Medicine* in 1979 - entitled: "Selective primary health care: an interim strategy for disease control in developing countries" (Walsh and Warren 1979) – suggested the costs of PHC approach were too high. The proposed approach was instead to fight against a limited number of diseases by concentrating on specific interventions that, according to the authors, would be most cost-efficient: vaccinations, promoting longer breast feeding, anti-malaria activities and oral rehydration. This approach prioritised rapid results over long-term objectives, based upon technical criteria and side-lining the notions of participatory decision-making and community-based approaches to health (Van Olmen et al. 2012). It represented the start of a movement, called Selective PHC, in a direction argued to be exactly opposite to the Alma Ata Declaration (Italian Global Health Watch 2008).

International funders were also becoming wary of funding comprehensive, broad-based programmes. Having vertical, definable, and time-limited programmes

that could be changed every few years, suited both donor agencies and donor governments (Hall and Taylor 2003). Newell (1988), Green (1999) and others warned about a threat of Selective PHC and called the attempts to alter it "a counter-revolution" and "a form of health feudalism that is destructive rather than an alternative, attractive to professionals, financing agencies and governments that are seeking results in the short term"(Newell 1988, p.903).

The WHO 2000 'World Health Report, Health Systems: Improving Performance' put the failure of PHC to achieve its goal down to inadequate funding and insufficient training and equipment for health workers (Hall and Taylor 2003), while the 2008 'World Health Report - Primary Health Care (Now More Than Ever)' issued on the 30th anniversary of Alma-Ata Conference (WHO 2008) was seen as an attempt to "resurrect PHC" (Takemi and Reich 2009).

Political and corporate interests continued to influence WHO's later years. After the election of Dr. Hiroshi Nakajima as WHO Director-General in 1988, USA froze its contributions as it disputed numerous WHO initiatives such as the promotion of the International Code on Breast Milk Substitutes, and the launching of the Essential Drugs Program, fiercely opposed by the pharmaceutical industry (Italian Global Health Watch 2008). With WHO budget reduced, programs began to be financed *ad hoc* through extra-budgetary funds provided by various donors and by the early 1990s such funds represented 54% of the entire budget of the WHO (Italian Global Health Watch 2008). The growing prominence of extra-budgetary funds raised concern that "few richer member states and powerful external individual donors and alliances may direct WHO about where the organization's efforts and funds should be spent, by supporting specific programmes and not others, by making *ad hoc* decisions, rather than developing strategic policies over the longer term"(Missoni 2008, p.6).

Between 1948 and 1998, the WHO moved from being the unquestioned leader of international health to being an organization in crisis (Brown et al. 2006). The prestige of the WHO got a boost in 1998 after the election of the former Prime Minister of Norway, Gro Harlem Brundtland as the WHO Director General. Her 1998-2005 tenure, although marked by initiatives such as the Framework Convention

on Tobacco Control, in general reflected the adoption of a policy approach similar to that promoted by the World Bank and was followed by more proliferation of activities financed by extra-budgetary mechanisms which soon greatly outnumbered those funded by the WHO regular budget (Italian Global Health Watch 2008). Some of those activities became to be known as Public-Private Partnerships (PPPs).

Defined as "a collaborative relationship which transcends national boundaries and brings together at least three parties, among them a corporation (and/or industry association) and an intergovernmental organization, so as to achieve a shared health-creating goal on the basis of a mutually agreed division of labour" (Buse and Walt 2000, p. 550), PPPs later were also referred to as Global Health Initiatives (GHIs) (Walker 2009). Missoni (2008) attributes to Brundtland's tenure at the WHO the promotion of 'partnerships and other interactions with the corporate sector' – among those she had strongly supported was the Global Alliance on Vaccines and Immunizations (GAVI), and the GF. Although Missoni concludes that at the end of Brundtland's mandate, WHO's international credibility had been restored, others (Brown et al 2006; Hawkes 2011; Savedoff 2012) argued that in its later years, with the extra-budgetary funding by Western donors earmarked for specific programmes, WHO's agenda was distorted, and it was eclipsed by PPPs – its own creation:

> Despite its past accomplishments, WHO fits increasingly uneasily into a world with a growing number of international players who seem fleeter of foot and deeper of pocket. Set up as an agency to provide advice to governments at a time when government health departments were the prime movers in health policy and delivery, it seems *passé* beside such upstarts as the Global Fund to Fight Aids, Tuberculosis and Malaria, the GAVI Alliance, and private philanthropies (Hawkes, 2011).

PPPs as a trend in vertical programming, received much criticism (Levine 2006; Garrett 2007) as causing more problems than they solve: "... priority should go toward activities that are part of the global public goods agenda, including setting norms and building knowledge within public health, and away from operational tasks and advocacy for the specific "cause of the day" diseases" (Levine 2006, p.1016). Being vertically structured, they may create "stand alone programmes" when being put on the ground in countries (Drew 2005c, p.13). PPPs were put in question for focusing "on particularistic issues" and lacking "the permanent authority, ongoing

financial commitments, and the continuity needed to address major global problems over the long term" (Forman and Segaar 2006, p. 208). Some have questioned the legitimacy of global PPPs (Missoni, 2008).

1.4.3 The emergence of neo-liberalist agenda: a 'New Age' in global health

The rise of neo-liberalism following the 1970s decline of the welfare state (Coburn 2000) manifested in the conservative anti-government-bureaucracy backlash of the 1980s, "epitomized by Reagan and Thatcher and the fall of the Berlin Wall in 1989" (Savedoff 2012, p. 5), while the USSR's dissolution in 1991 put the end to the "politics of public health as a by-product of the Cold War" (Osakwe 1972, p. 118). These events fundamentally affected the global health architecture and paved a way for the emergence of new and powerful players.

In 1993, the World Bank, one of the pillars of neo-liberalist policies, released a famous 'Investment in Health' world development report (The World Bank, 1993) that asserted a failure of the then-existing various health systems and proposed a new approach for finance and organisation of healthcare. Among the measures it suggested were:

- Cost-effectiveness as the main tool for choosing among possible health interventions;
- Governments were advised to decide their countries' health priorities and resource allocation policies according to cost-effectiveness and disability-adjusted life years (DALY)[8]. Less cost-effective services such as tertiary care, heart surgery, treatment of highly fatal cancers, etc. should not be for paid by government;
- Only a minimum package of essential services should be paid for by the government;
- Governments should privatise healthcare services, by selling the public goods and services, and buying services from the private sector;

[8]In 1990, Harvard University developed the concept of Disability Adjusted Life Year (DALY), which was launched by the World Bank and WHO as a measure for the burden of disease.

- Government financing of public health and essential clinical services would leave the coverage of remaining clinical services to private finance, mediated through insurance (The World Bank 1993).

The World Bank report reflected a major change in the nature of healthcare service delivery in resource-poor countries and made little mention of the term 'Primary Health Care'. Instead, it considered the delivery of healthcare services in terms of the economic benefit that improved health could presumably deliver, and saw health improvement mainly in terms of improvement of human capital for development, rather than as a consequence and fruit of development. The Bank approach became known as 'Health Sector Reform'. It heralded an emphasis on using the private sector to deliver healthcare services while reducing or removing the role of state services. User fees, cost recovery, private health insurance, and public–private partnerships became the 'buzz words' for healthcare. In the next 20 years, these measures became to be implemented worldwide (Civaner n.d.).

With the World Bank's entry as a major player in health policy, the WHO began to lose its international leadership capacity (Ewig 2010) and was soon displaced as "the most influential actor in health" (Van Olmen et al. 2012, p.774).

Numerous studies have critiqued the 'global blueprint' for health policy advocated by the World Bank (Whithead et al. 2001). The focus of the critique was, for instance, on the 'cost-effectiveness approach', which was believed to obscure the complex, social nature of illness and resulted in a number of problems, including reduced access to health services, cost inflation, and resource misallocation (Homedes and Ugalde 2006; Janes et al 2006; Waitzkin et al 2007).

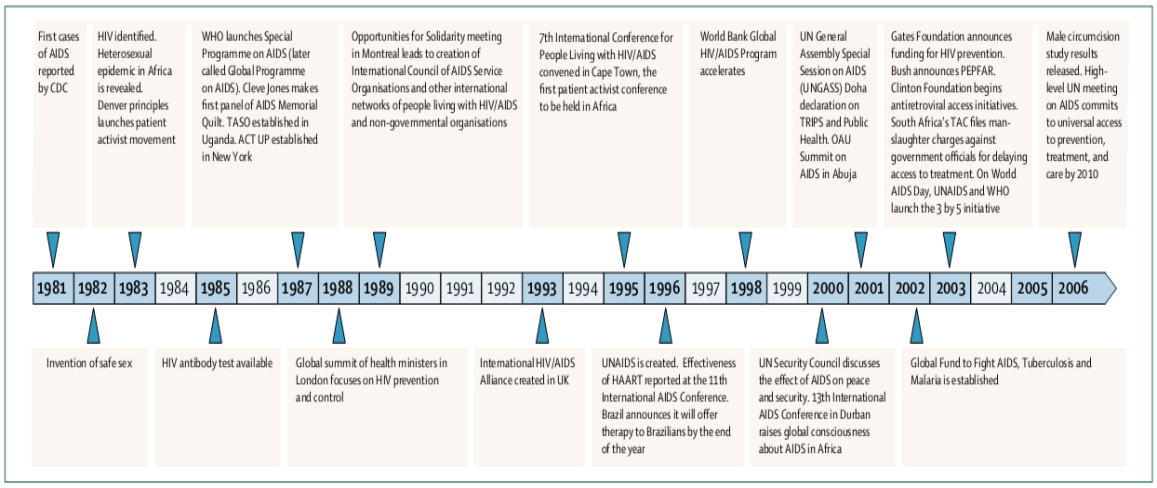
Whitehead et al (2001, p.833) have indicated that attempts to undermine public services posed "threats to equity in the well-established social-welfare systems of Europe and Canada". For fragile middle- and low-income countries, the introduction of user fees for public services, and the growth of out-of-pocket expenses for private services represented a "poverty trap".

At the end of the 1990, the critique came 'from within' the World Bank, when its former chief economist Joseph Stiglitz articulated his view of neo-liberal

policies as theoretically and historically inaccurate, and lacking transparency (Stiglitz 1998). Stiglitz's critique may have paved the way for some loosening of the World Bank's position on the role of state regulation, which coincided with the rise of the UN's new human development paradigm. The key to the new paradigm was the Human Development Index (HDI) that included, in addition to GDP, the average measure of life expectancy, literacy and educational attainment (Ewig 2010). Ultimately, however, global health policy remained predominantly neo-liberalist, including the way health reforms were implemented in post-communist countries.

1.4.4 The global AIDS response architecture before the GF

Figure 1.1 Chronology of the global AIDS response (Merson et al 2008, p.482)



The first attempt at institutionalizing the global AIDS response was a launch by WHO in 1987 of its Control Programme on AIDS (CPA) "to direct and coordinate the global response to the pandemic" (Merson et al 2008, p. 480). The CPA's first director was Jonathan Mann. Renamed in 1988 as the Global Programme on AIDS (GPA), it became the largest programme in WHO's history. Mann's leadership received much credit for having raised global awareness of the AIDS pandemic and for his courage to demand a human rights-based response to the pandemic (Fee and Parry, 2008), by recognizing and reaching out to activist and community groups and networks of people living with HIV/AIDS (PLWHA). Despite its achievements, GPA was unable to muster the political will required to

mount the necessary response in affected and donor countries, in part because of its inability to engage nations' leaders in the sensitive policies linked to HIV transmission (Merson et al. 2008).

Serious tensions existed among UN agencies and HIV/AIDS experts regarding the priority that should be given to different approaches to HIV prevention. Some felt that HIV/AIDS should be tackled primarily as a public health problem with an emphasis on shorter term, behavioural interventions such as condom promotion and social marketing, sex education of youth in and out of school, voluntary HIV testing and counselling, and treatment of sexually transmitted diseases (STDs). Others believed that the pandemic could best be controlled with a longer-term development approach that addressed structural determinants that increase vulnerability to HIV infection, such as gender, human rights, poverty and community development. The diverging views on how best to combat HIV impeded the ability of UN agencies and bilateral donors to harmonize their efforts at the country level, and polarized the HIV/AIDS community (Merson et al. 2008). In 1990, Mann resigned over tensions with WHO's Director-General Nakajima (CGD 2009). An external review led to the decision to close the GPA in 1996 and replace it with a new agency to coordinate the work of the UN on AIDS - the UN Special Programme on HIV/AIDS (UNAIDS), fully established in 1997.

The push for the new programme came from the donors who hoped that a slimmer and more efficient UNAIDS, with emphasis on coordination rather than direct financial support to countries, would require less funding than the GPA (Merson et al. 2008). The role for the newly created UNAIDS was to:

> .. achieve and promote global consensus on policy and programmatic approaches; strengthen the capacity of the UN system to monitor trends and lessons learned and to ensure that appropriate and effective policies and strategies are put into operation at country-level; strengthen the capacity of governments to draw up comprehensive national strategies, and to coordinate and implement effective HIV/AIDS activities at country level; promote broad-based political and social mobilization to prevent and control HIV/AIDS within countries, ensuring that national responses involve a wide range of sectors and institutions; and advocate greater political commitment in responding to HIV/AIDS epidemics at global and country levels, including the mobilization and allocation of adequate resources for HIV/AIDS. (WHA 1993)

Initially co-sponsored by seven agencies [9], UNAIDS was led since its inception until 2008 by its founding Executive Director, Dr. Peter Piot, with whom the program has become closely identified (CGD 2009)[10]. The organisation's first years were challenging. Unlike the co-sponsoring agencies, each with a specific mandate, the UNAIDS, despite the broadly set goals, did not have a mandate to coordinate the work of the UN and "to reach beyond the organization to all sectors to forge a global agenda on HIV and AIDS" (CGD 2009, p. 5).

As a mechanism for in-country coordination, UNAIDS introduced UN Theme Groups on HIV/AIDS – "the main vehicles through which agencies in the [UN] system coordinate their activities at the country level" (UNAIDS 2005, p. 15). UN Theme Groups often had difficulties getting started, because of lack of collaboration between UN co-sponsors and other donors [11]. Gradually, donor governments diminished their contributions, which led to a decrease in UNAIDS staffing and programmes at the country level (Merson et al. 2008).

While it is generally acknowledged that UNAIDS, in its umbrella function, played an important role in harmonizing AIDS policies across agencies and made an important contribution to fighting the pandemic, however, after a release of UNAIDS five year review (UNAIDS 2002), there were still questions remaining on what it was meant to be: a sum of all UN activities on HIV/AIDS or of the parts of its cosponsors? Or a Geneva-based Secretariat with regional and country outposts under the loose rubric of multi-sectoralism and an expanded response? (CGD 2009). And while it has played a valuable role in monitoring the epidemic, forecasting future needs, and influencing national governments to develop their HIV/AIDS policies, much of its success can be attributed to the era in which it was created and the void in leadership that needed to be filled. Now that this void has been filled by numerous agencies, advocacy groups, and movement toward integration of HIV/AIDS efforts into larger health and development goals, many question the role of a standalone

[9] UNICEF, UNDP, UNFPA, UNDCP, UNESCO, WHO and the World Bank.
[10] Piot stepped down from his post at UNAIDS in December 2008. He is currently the Director and Professor of Global Health at the London School of Hygiene and Tropical Medicine (LSHTM. n.d.).
[11] The author observed these challenges first-hand during her work for UNAIDS in Ukraine.

agency dedicated to a single disease (Das and Samarasekera 2008; Schneider and Garrett 2009), or even ask: do we need UNAIDS? (CGD 2009)

Parallel to the developments at the UN, in the 1990s, several foundations, bilateral donors, and international NGOs launched efforts to tackle HIV/AIDS focused specifically on developing countries. Following the tradition of its work in population and reproductive health, HIV prevention efforts funded by the US government in these years tended to be designed by public-health experts and implemented by US-based non-profits funded through the US Agency for International Development (USAID) (Merson et al 2008).

Towards the end of the 1990s there was no global significant framework in place to combat AIDS, and no global treaties or benchmarks to coordinate national HIV/AIDS policies. At the national level, 'first generation' government programmes began to be established and by the early 1990s almost all developing countries had national HIV/AIDS control programmes - frequently criticized for lacking national ownership and ineffectiveness (Merson et al 2008).

On June 25-27, 2001, at the urging of UN Secretary General Kofi Annan and U.S. ambassador to the UN Richard Holbrooke, a UN General Assembly Special Session (UNGASS) entitled 'Global Crisis - Global Action'(UN 2001), gathered in New York to address the security implications and long-term financing efforts of HIV/AIDS, marking the first time in the UN history that a disease had been the focus of a General Assembly (Schneider and Garrett 2009). Heads of State and Representatives of Governments issued the 'Declaration of Commitment on HIV/AIDS' that set out national targets and global actions to reverse the epidemic and committed to submit country progress reports (UNAIDS 2001). The final document of the UN Special Session indicated $7-10 billion as the annual amount the international community should allocate to tackle the 'global crisis' (Italian Global Health Watch 2008).

1.5 The Global Fund era beginning

"..the Global Fund is you."

Michel Kazatchkine, the ex-Global Fund Executive Director[12]

1.5.1 The creation of the Global Fund

The leading donor countries (the Group of Eight – G8), the US government, and organisations in the UN system have paved the way to the establishment of the Global Fund. The idea of an independent funding mechanism to fight infectious disease was first articulated at the 1998 G8 summit in Birmingham, UK (CRS 2005).

Originally, the list of diseases targeted for the global health fund was broader. Initially called the 'Massive Attack on Diseases of Poverty', the initiative to tackle malaria, tuberculosis, unsafe pregnancy, AIDS, diarrheal diseases, acute respiratory infections and measles, was articulated in the WHO Director-General concept paper that also called for increased efforts to eradicate or eliminate Guinea Worm, polio and leprosy by 2005, and to make "monumental improvements in the delivery of effective and responsive health care" (WHO Director-General's Office 1999). The list of diseases continued to evolve: by March 2000, it narrowed to TB, HIV/AIDS, malaria, unsafe childbirth and vaccine-preventable diseases (WHO Director-General's Office 2000), and at the G8 Experts' Meeting on Global Health Issues on April 19–20, 2000, the discussion finally focused on the three major infectious and parasitic diseases - HIV/AIDS, TB, and malaria - identified as the highest priority areas among others through the G8 process (G8 Experts Meeting 2000).

The momentum for establishing a new fund grew at the G8 summit in Japan, resulting in adoption of the 'G8 Communiqué Okinawa 2000,' which declared, 'We have widespread agreement on what the priority diseases are… a new strategy to harness our commitments..and to define the operations of this new partnership' (G8 Communique Okinawa 2000).

As noted earlier, criticisms of existing aid programmes prompted the establishment of the GF. A large part of the impetus for creating the GF came from

[12] Cited in Decosas (2012).

donors who no longer wanted to channel money through existing aid programmes (Radelet 2004). The impetus for the establishment of the GF also came from a growing and "an increasingly sophisticated and diverse group of community partners and researchers" and AIDS activists (Merson et al. 2008, p. 484) who engaged in treatment activism following the discovery of HAART[13] in 1996.

In the US, beginning in 1999, several U.S. Congress Representatives introduced various legislative acts to establish a special fund on AIDS, one of which passed both the House and Senate and was signed into law in August 2000[14].

UN Secretary General Kofi Annan was at the core of the international effort to create an independent funding vehicle. On April 26, 2001, when addressing a summit on HIV/AIDS and other infectious diseases in Abuja, Nigeria, he called for establishing "a war chest on AIDS" (BBC 2001) and announced he would donate his $100,000 Philadelphia Liberty Medal award to it (Schuster 2001). Annan's proposal attracted considerable attention. On May 11, 2001, Annan and Nigeria's President Olusegun Obasanjo came to the White House, to hear President George W. Bush make a "founding pledge" of $200 million to the Global Fund (CRS 2005).

The creation of the GF was endorsed by UNGASS in June 2001, and by the G8 summit in Genoa, Italy, in July 2001. At the first meeting of its 18-member Board on January 28–29, 2002, GF issued its first call for proposals (Kapp, 2002), and in April 2002 awarded a total of US$378 million over two years to 40 programs to fight the three diseases in 31 countries (GFATM 2002), one of which was Ukraine.

1.5.2 The U.S. influence over the Global Fund

Since its founding pledge to the Global Fund in 2001 and until the present, the U.S. has exerted a strong influence over the GF: U.S. contributions have remained higher than of any other country, U.S. officials have served on various GF

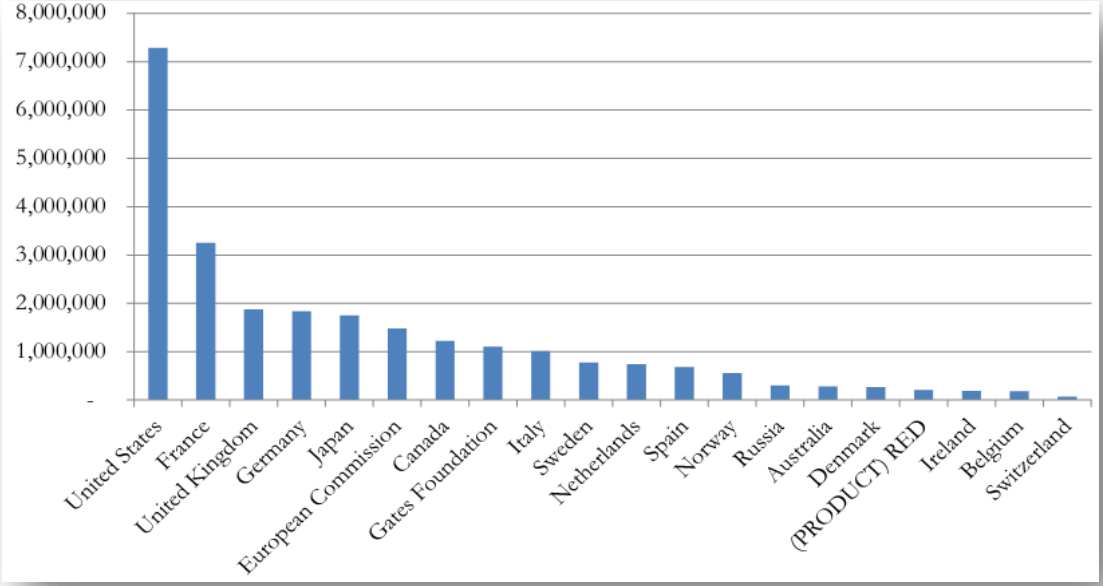
[13]Highly Active Anti-Retroviral Treatment.

[14] The *Global AIDS and Tuberculosis Relief Fund of 2000*, P.L. 106-264, was signed into law on August 19, 2000 and called for negotiations between the U.S. Secretary of the Treasury, the World Bank and others in order to create a 'World Bank AIDS Trust Fund' (Sheehan 2008, p.184).

Boards, and the U.S. Congress has steadily raised its appropriations to the Fund. At the same time, Congress has passed laws that limit U.S. spending on the Fund[15].

Since the GF establishment, the extent of U.S. involvement in the GF is an ongoing discussion (Kaiser Family Foundation 2013). Much of this scrutiny comes from the fact of the U.S. being the largest single GF contributor (see Figure 1.2):

Figure 1.2 Cumulative GF Contributions by Donor (2002-May 2013) in USD (CGD 2013, p.10)



The debate has mainly developed along the following lines:

(a) whether the U.S. should maintain its GF contributions; and

(b) as a part of a more general political debate to reduce aid spending.

Opponents of the GF argue that Congress should forego pledges to the GF in the interest of funding U.S. bilateral programmes such as PEPFAR (Truong 2013). The supporters of spending cuts on foreign aid, among them former Representative Ron Paul (R-Texas), argued that the government must prioritise

[15] A condition set through the Tom Lantos and Henry J. Hyde 'U.S. Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008' (P.L. 110-293), prohibited U.S. contributions from exceeding one-third of all contributions (CRS 2011). The U.S. contribution limit meant to encourage greater global support for the Fund (CRS 2011).

national security and domestic issues over foreign aid. In his 2012 campaign, Republican Presidential Candidate Mitt Romney advocated to change the entire U.S. foreign assistance system by offering aid in 'Prosperity Pacts' – "America will send you money only if you drop all existing trade and investment barriers objectionable to U.S. companies"(Garrett 2012).

Opponents of the aid cuts, such as U.S. Senator Patrick Leahy (D-Vermont), Chairman of the Appropriations Subcommittee on State and Foreign Operations, argue that "foreign aid totals less than 1 percent of the federal budget, yet it is a crucial investment in our national security"(Leahy 2011).

Both levels of political debate underline the special role of the U.S. in the GF and explain the scrutiny placed on its operations that are constantly reviewed by various U.S. agencies.

In June 2005, the U.S. Government Accountability Office (GAO) reported that the Fund had limited capability to monitor and evaluate grants, which raised questions about the accuracy of its reported results (GAO 2005) and indicated that the Fund's documents had not consistently explained why it provided additional funds for grants or why it denied disbursement requests. In its response to the GAO report, the U.S. State Department stated: "The lack of easily and publicly available documentation to support decisions on grant performance, disbursements and renewals is one of the most troubling deficiencies [of the Fund]"(GAO 2005, p. 59).

Members of Congress have advocated for stronger oversight of the GF. At a March 2007 hearing held by the Subcommittee on Africa and Global Health, Rep. Adam Smith, D-Wash., expressed reservations about the GF oversight capacity:

> The information and accountability that Congress has come to take for granted through bilateral programs are not available through the GF, and many of the primary recipients of the GF grants are governments with a history of corruption and fraud and/or limited capacity to properly manage large sums of money in their health sectors. [T]he absence in the GF of a robust reporting and monitoring mechanism, at both the primary and sub-recipient levels, is an open invitation for waste in these countries and a tragic loss of opportunity to save lives. The implementation of a system that provides accountability and transparency would seem vital to continue the expanded support of the GF in the future. (cited in CRS 2008, pp. 12-13)

Interestingly, in this statement, the GF is being criticized *in comparison to traditional aid programmes* for lack of accountability in funding 'corrupt governments'. As noted above, the criticism about how the donors engaged with governments pre-GF, was one of the arguments in support of the GF establishment.

The Congressional Research Service (CRS) 2008 report voiced criticisms of the GF oversight mechanisms that were deemed "not strong enough to protect against wasteful spending, particularly in countries that have a well-documented history of corruption and poor financial management"(CRS 2008, p.12).

In an effort to strengthen oversight of the Fund's grants, Congress included a provision authorizing the Secretary of State to withhold 20% of the U.S. contribution[16] until the GF could demonstrate improved oversight and accountability in grant disbursement, while also allowing the Secretary to waive the requirement, if she determined that a waiver was important to the national interest (CRS 2011). The existence of such provision underlines the importance of the mandate given to the Secretary of State in relations with the GF. From 2009 to 2013, this position has been held by Hillary Clinton, a "politically powerful Secretary of State"(Goldberg 2012) who greatly increased the influence of the State Department over the GF affairs.

A recent report suggested that the role of the U.S. was shifting to ensure "the appropriate balance between U.S. support for multilateral efforts, such as the Global Fund, and bilateral programs, which allow for increased control and oversight" (Kaiser Family Foundation 2013).

In one of her final acts as Secretary of State, Hillary Clinton created the Office of Global Health Diplomacy (OGHD) as part of the State Department. This move suspended a Global Health Initiative, launched by President Obama in 2009 (CSIS 2013). The OGHD is supposed to lead U.S. international efforts in global health and to oversee U.S. engagement with the GF. In February 2013, a report by the Global Policy Center entitled 'Global Health Policy in the Second Obama Term', questioned whether the new presidential administration was able "to sustain and consolidate its diplomatic outreach for global health"(Morrison 2013, p. 1).

[16] Reinstated at 10% in 2012 (Kaiser Family Foundation 2013)

1.6 The Global Fund mission and structures

1.6.1 The GF guiding principles

According to the GF Framework Document, the purpose of the Fund is to attract, manage and disburse additional resources through a new public-private partnership that will make a sustainable and significant contribution to the reduction of infections, illness and death, thereby mitigating the impact caused by HIV/AIDS, tuberculosis and malaria in countries in need, and contributing to poverty reduction as part of the Millennium Development Goals (GFATM 2001).

The guiding principles of the Global Fund include the following:

A. The Fund is a financing instrument, not an implementing agency;
B. The Fund is intended to leverage financing for AIDS, TB and malaria;
C. The Fund will base its work on programs that reflect national ownership and respect country-led formulation and implementation processes;
D. The Fund will seek to operate in a balanced manner in terms of different regions, diseases, and interventions;
E. The Fund will pursue an integrated and balanced approach covering prevention, treatment, and care and support in dealing with the three diseases;
F. The Fund will evaluate proposals through independent review processes based on the most appropriate scientific and technical standards that take into account local realities and priorities;
G. The Fund will seek to establish a simplified, rapid, innovative process with efficient and effective disbursement mechanisms, minimizing transaction costs and operating in a transparent and accountable manner. (GFATM 2001, p. 1-2)

As a 'War Chest for Fighting HIV/AIDS' (Lewis 2005), the GF positioned itself as distinct from other donors and intended to combat the global burden of the three diseases by delivering aid in new, innovative ways (Glassman 2012). The GF

functions as a financial instrument, rather than an implementing agency (Schneider and Garrett, 2009). The *focus on funding* serves to define it as a form of institutional innovation among traditional multilateral institutions (Walker 2011). The GF does not have a country representative office and relies on the Country Coordinating Mechanism to govern and oversee its programmes.

A *focus on civil society* is another key principle of the GF. By making an engagement of civil society and those affected by the diseases in service provision as a requirement for countries' eligibility to receive funding (Rivers 2005), the GF has been strongly promoting NGO-centred service delivery. The engagement of civil society organizations (CSOs) is predicated on the special nature of GF programmes, which view CSOs as having better access to marginalised and vulnerable groups such as men who have sex with men, sex workers, people who inject drugs, and others (GFATM 2013), in comparison with slow and bureaucratized processes in state health care:

> The Global Fund found that, on average, civil society organizations are essential, successful and high-performing implementers of Global Fund grants and that direct financing to civil society PRs can improve the speed of finance and add additional capacity. (GFATM 2007, p.13)

In the context of country-level public health systems, GF promotion of a special role for civil society organisations is viewed as an extension of the neoliberal structural adjustment policies (SAPs) promoted by the World Bank, which were seen to by-pass government in favour of civil society (Walker 2011).

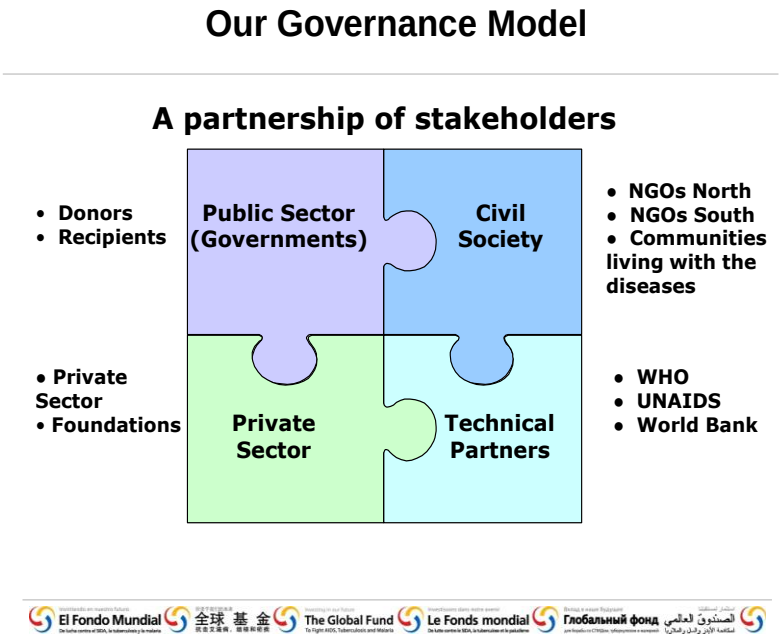
1.6.2 The GF Board as the constituency based governance model.

Definitions of the term'governance', given by Stoker (1998), Mayntz (2003), Schuppert and Zürn (2008) and other authors, differentiate between an analytical and a normative understanding of governance (Lauth 2012). In regard to the policy sphere, I have accepted the definition of governance by Christiansen as:

> .. the production of authoritative decisions which are not produced by a single hierarchical structure, such as a democratically elected legislative assembly and government, but instead arise from the interaction of a plethora of public and private, collective and individual actors. (Christiansen et al 2003, p. 6)

The GF's constituency based governance model is core to the organization's identity as a public-private partnership. The GF Board stresses that its effective functioning "requires active and informed engagement by all constituencies"(GFATM, n.d.1).

Figure 1.3. The GF Governance Model puzzle (Guarinieri 2011)



The Board is the supreme governing body of the GF and exercises the following core functions: strategy development, governance oversight, commitment of financial resources, assessment of organisational performance, risk management, partnership engagement, resource mobilisation and advocacy (GFATM,n.d. 2).

Analysis and discussion of the GF Board composition and its impact on decision-making was provided by Brown (2007), Davinia (2009), Missoni (2008), Walker (2011), Spicer (2009) and some others. It is briefly summarised below.

According to the GF 'Operating Procedures of the Board and Committees' (GFATM, 2011b), seats with voting power on the Board of the GF are allocated in the by-laws to representatives of donor countries, developing countries, civil society, the private sector, private foundations, non-governmental organisations, and the communities living with the diseases.

As a new institutional form, the GF was challenged to demonstrate accountability to its donor countries, to make a case for its legitimacy relative to

traditional multilateral organisations in the UN system (Forman and Segaar 2006), and to demonstrate effectiveness in terms of using its resources to achieve intended health outcomes and impact (Walker 2009). Gaventa (2006) noted that this approach is also used by donors to argue that the biases of elitism or a lack of public accountability found in traditional institutions, such as those of the state, can be off-set by investing in a vibrant civil society.

The Five-Year Global Fund Evaluation has concluded that the GF had an inclusive governance structure, involving the private sector (for-profit and non-profit) in addition to donor and recipient countries (Gerrard and Ooi 2012). When the GF was originally constituted as a private foundation in 2001, the 18 voting members on its Board were comprised of seven donor country delegations, seven developing country delegations and four delegations representing civil society and the private sector (Walker 2011). With the growth of GF, donor delegations began to predominate on the Board. The GF 24-member Board comprises 20 voting members, with one vote each, and four non-voting members. 20 voting members are divided into two 'voting blocs': a 'donor voting bloc' with 10 seats representing donor states, the private sector and private foundations, and the 'the implementer voting blocs,' with 10 seats consisting of developing states and NGOs (Davinia 2009), of them seven are representatives of developing states (divided by regions), three seats are reserved to NGOs from both developed and developing countries (one seat each) and representatives of 'people living with disease'.[17]

Garrett Brown (2007) has described the governance at several levels of the GF and, in particular, examined the practice of multi-sectoral deliberation within the Board. His findings suggest that, despite the presumed balance between donor and recipient states, the unequal political influence and power between them was present on the GF Board, manifested by the fact that the donor states often met prior to GF meetings to discuss political strategy and to organise voting caucuses. Brown suggested that such 'voting caucuses' would give donors an unfair advantage to push through various motions or funding decisions. Remarkably, when several recipient countries lobbied the GF donors for extra resources to organise their own pre-Board meetings, their request was rejected. The implication of forming and maintaining the

[17] In 2011, the amended Bylaws provided that there were eight representatives from donors (GFATM, 2011).

unfair advantage of a donor caucus, is that the deliberation process between Board members effectively becomes a process of interest-based preference maximisation. Some of Brown's study participants, who were GF Board members, also suggested that there were problems with accountability, in terms of there being 'no consistent idea of who the Global Fund is accountable to' and that 'the Global Fund is accountable only to donor states'. It was also observed that within the Board, donor states had an effective veto power by alluding taking certain decisions that might threaten future funding. The example of this veto power was evidenced by the U.S. willingness to withhold funds until certain programs are eliminated or changed to the Bush administration's liking, for example by continuously pressuring the GF to fund abstinence faith-based ABC[18] programs. Brown argues that by having an effective veto power, donor countries were able to colonize the deliberative process by forcing the removal of various alternatives from the debate or by using the threat of future funding reductions as a means to coerce outcomes (Brown, G. 2007). His study also suggested the existence of possible disconnects between the Board representatives and their constituents[19].

Some INGOs developed strong links to the GF Board. In May 2011, one of the trustees of the International HIV/AIDS Alliance[20], Martin Dinham, was appointed Chair to the GF Board. As of January 2013, two other members of the Alliance were on the GF Board: Alliance Executive Director Alvaro Bermejo, was appointed as a Developed NGO Delegation Board member, and the Alliance's Latin America and Caribbean regional representative, Javier Hourcade Belloqc, was one of the NGO Representatives of the Communities Living with the Diseases.

To summarise, the governance structures of the GF (Board) appear multi-sectoral mainly in rhetoric, with the power balance shifted towards donors and prolific Western NGOs.

[18] ABC- Abstinence, Be Faithful, use Condom.

[19] Brown's suggestion was confirmed by author's earlier experience in Ukraine, when trying to determine who represented the country on the GF Board. The GF web-site listed a name of a MOH official as the GF Board member for a number of years. However, there was no knowledge of that person making any public statements or conducting meetings in Ukraine in regard to her GF function.

[20] An INGO with headquarters in UK. More information is provided in Chapter 2.

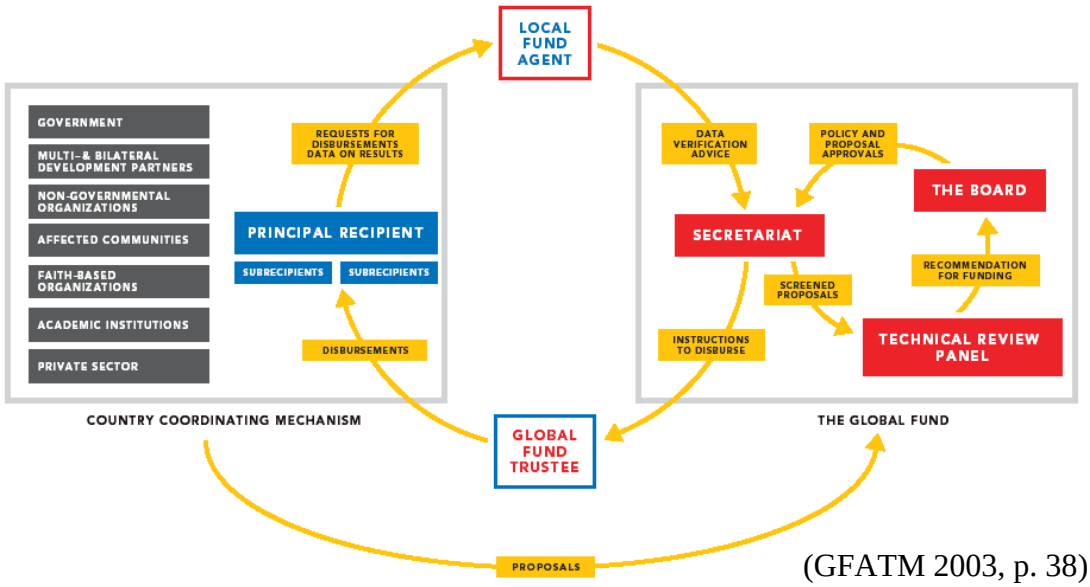
1.6.3 Governance at the country level. The GF country ownership model and its limitations

The importance of country ownership was recognized in the Paris Declaration that defined it as countries exercising "effective leadership over their development policies, and strategies" and coordinating development actions (OECD, 2005).

Country ownership is one of the core principles of the GF: "The Global Fund will base its work on programs that reflect national ownership and respect country led formulation and implementation processes" (GFATM 2001, p. 91).

Unlike most multilaterals, the GFATM does not have in-country presence or representation. Instead, it relies on a model where a Country Coordinating Mechanism (CCM) develops proposals, Principal Recipients (PRs) receive grants and implement programmes and a Local Fund Agent (LFA) contracted by GFATM provides in-country monitoring.[21]

Figure 1.4 The Global Fund implementation model



(GFATM 2003, p. 38)

[21] The LFA is typically one of the large multinational accounting firms – PriceWaterhouse Coopers, KPMG, or others (Taylor, 2011). The LFA role is to assess the financial and operational capacity of a PR, and after the proposal is approved, to verify PR reports, progress updates, etc. LFA reports to GF Secretariat are not disclosed to CCM or other country stakeholders.

The CCM is the primary mechanism GF relies on to exercise the country ownership principle, and an eligibility criterion to receive GF money. GFATM guidelines encourage CCMs "to be broadly representative of all national stakeholders in the fight against the three diseases" (GFATM 2005, p. 3) by creating a forum that includes national and international private actors such as local and international NGOs in addition to government (Walker 2011).

In each GF round,[22] the CCM develops and publishes a National Strategy for the development of a GF country proposal that presents the country's understanding of its HIV epidemic, national HIV data, existing resources to combat the epidemic, the groups of highest risk to HIV transmission, etc. This document serves as a base for selecting a PR, who is then responsible for preparing a country proposal that is approved by the CCM and sent to the GF. Proposals are reviewed by the GF Technical Review Panel (TRP)[23] and approved by GF Board.

Analysis of the country ownership principle in global health and its realization in the GF systems has been done by Radelet and Caines (2005); Sridhar and Batniji (2008), Spicer et al (2009), Walker (2011), Garmaise (2009; 2013), and others. This section introduces the key arguments of the debate over the GF country ownership, while Chapter 6 on the CCM in Ukraine places these arguments onto the country context.

Walker (2011) argues that the 'country ownership' model of governance that the GF has promoted at the country level is a form of input-oriented legitimacy that is needed by the GF to justify that it is spending money according to the needs of the recipient countries.

At the same time, as argued by Garmaise (2013), country ownership was never supposed to mean that the GF should "write a blank cheque" and from the outset, limitations were placed on the application of the country ownership principle. One example of such limitations was the GF requirement that countries establish

[22] GF grants are given for five years. There were a total of 10 GF rounds of funding from 2002 to 2012. In November 2011, Round 11 was suspended. The New Funding Model is currently applied in funding grants to countries.

[23] TRP, an independent group of epidemiologic and public health experts that reviews the country proposals and ensures that proposed programs meet standards of scientific and technical rigor.

CCMs to make the country submission eligible. The presence of minimum CCM requirements has been criticized for allowing the GF Secretariat staff "to exercise a considerable amount of discretion in applying these requirements to the screening of proposals" (Garmaise 2009).

The mandate of the CCM is not clear. A UNAIDS study concluded that, while 80 percent of countries had "national AIDS authorities" with "a clear mandate to coordinate", only 41 percent had "authority to allocate resources" (UNAIDS 2005, p. 19). Functionally, they are often not the way governments or countries normally manage programmes (Radelet and Caines 2005). The World Bank Independent Evaluation Group (IEG) report concludes that CCMs lack both the authority and the resources to exercise effective oversight over GF grants, since they are not conventional governing bodies. CCMs have small secretariats that are only responsible for administration and execution of CCM decisions such as submitting proposals to the GF but are not responsible for implementing the GF program in the country. Rather, the Geneva-based GF Secretariat contracts directly with the PRs to implement the grants (IEG, the World Bank 2012).

The GF High-Level Panel Report in 2011 notes that while 'country ownership' was applied broadly across the GF model, there was no clear understanding of the term in practice:

> The Panel has heard the mantra of 'country ownership' invoked to explain and justify almost every aspect of the Global Fund's business model and decision the institution makes. Yet while 'country ownership' is a founding principle highlighted in the Framework Document, there does not appear to be a shared perception – inside or outside the Global Fund – about what the term means in practice. (High-Level Panel2011, p. 9)

The GF High-Level Panel Report noted that "constantly reinforced, but hazily defined, ideology of 'country ownership' …within the GF Secretariat has bred a culture of passivity in grant management. This practice confuses PRs, and leaves the grant portfolio vulnerable".(High-Level Panel 2011, p.65)

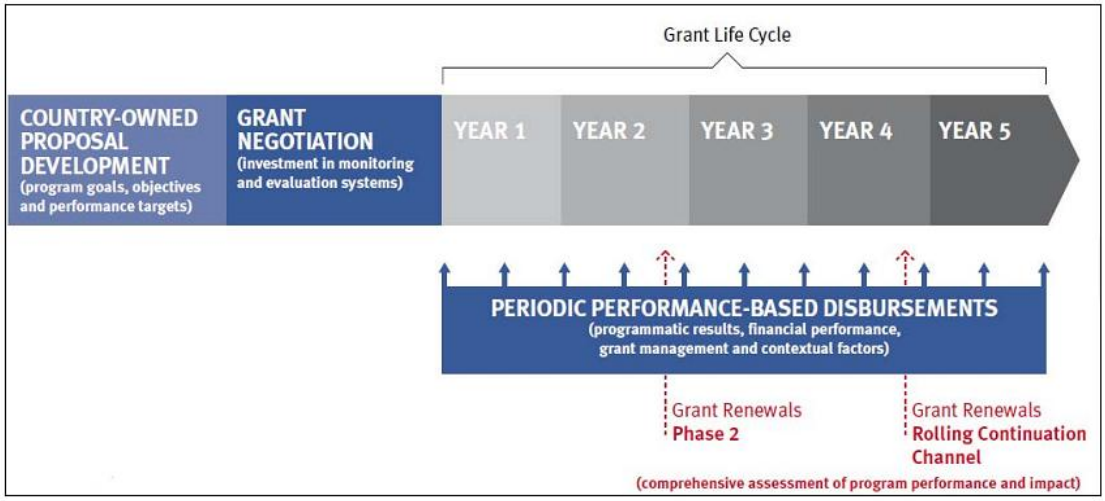
There are concerns that closer coordination among donors in the GF decreases the policy space of developing countries by shifting the balance of power

towards the "consortium of donors acting in unison"(Murray et al 2007, p.1018), while the perceived global unilateralism linked the global health agenda to the U.S. national interests (Kickbusch, 2002). The latter author has also suggested that as the debate over aid effectiveness continues to influence all the U.S. administrations, which have to fight severe domestic battles to justify foreign aid disbursements at the U.S. Congress, "the four Es – economics, effectiveness, efficiency, and evidence – become the battle cries for the development community" (ibid., p. 134). Translated into implementation discourse, the GF model of 'performance-based funding' originates from this political battle-field and is aimed to demonstrate to GF donors, particularly to the US, that its programmes are effective.

1.6.4 Performance-based funding and its criticism

The founding principle of the Global Fund — to provide funding to countries on the basis of performance — was meant to make it different from other aid agencies. In the words of President's Bush administration official, as cited in *The Wall Street Journal*, "we envision... a level of substantive accountability – meaning results – that's unheard of in international development assistance" (cited in Schoofs and Phillips 2002). The core belief embedded in the creation of the GF was that an organization that links funding to measured results and performance can be more efficient. To implement this belief, the GF created a system of performance-based funding (PBF). The GF funding process is described below.

Figure 1.5 Performance-based funding and the GF grant life cycle (GFATM 2009)

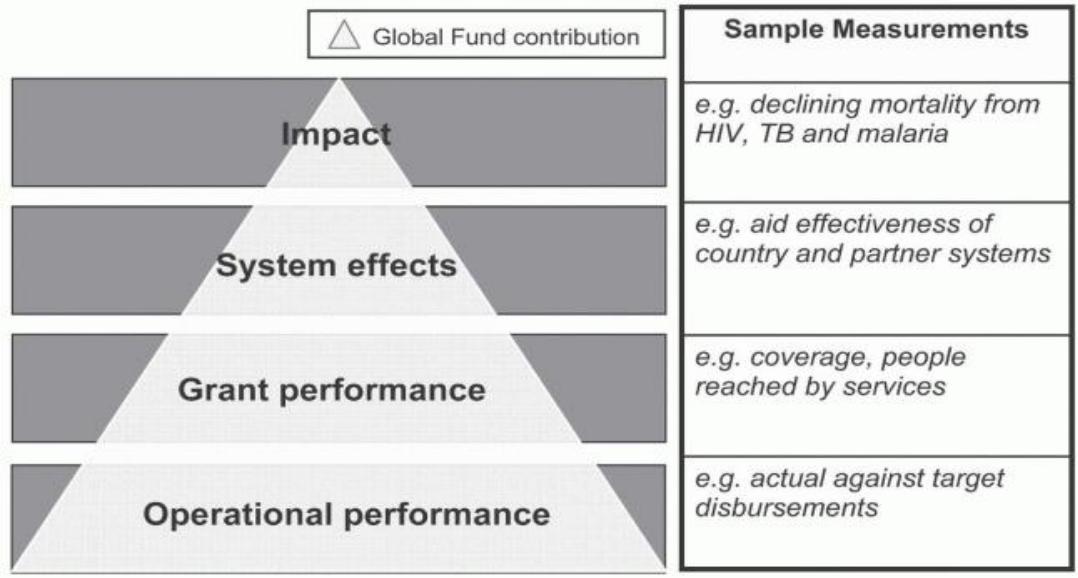


After the country proposal is vetted by TRP, the GF Board approves a proposal for a five-year grant, and the GF Secretariat signs a two-year grant agreement with the PR. The LFA conducts capacity assessment before the GF signs an agreement with a PR. If the results of assessment are satisfactory, the GF instructs the World Bank, the trustee of the GF, to disburse the first tranche of funds to the PR. The GF disburses subsequent tranches based on performance. After a grant's first two years - Phase 1- the GF reviews grant performance to determine whether the grant should be continued and if the Board approves continued funding, the grant enters Phase 2. PRs submit a Progress Update and Disbursement Request (PUDR), which consists of a progress report on the grant implementation and a request for funds for the next reporting period. The progress report includes information on the results of the grant against targets and information on expenditures. The PUDR is reviewed by the LFA and submitted to the GF Secretariat. Based on the assessment of the PUDR, the Secretariat assigns a performance rating to the grant on the following scale: A1 – exceeded expectations; A2 – met expectations; B1 – adequate; B2 – inadequate but potential demonstrated; and C – unacceptable (IEG, the World Bank 2012, p. 47). The PUDR process has been characterised as "overly complicated and time-consuming" (IEG, the World Bank, 2012, p. 51).

To access performance and overall impact of the agency, the GF has developed a four-tiered corporate performance management framework (Figure 1.6). Also called a 'Global Fund evaluation pyramid' (in Nahlen and Low-Beer 2007,

p.323), this framework is crucial to the GF to demonstrate that it is an effective financing instrument, contributing to the fight against the three diseases:

Figure 1.6 The Global Fund evaluation pyramid



In this scheme, the GF contribution is pictured by a light grey triangle. The framework starts from operational performance at the bottom, then moves to programmatic results (grants performance measurement), which then leads to effectiveness, and ultimately to impact in combating the three diseases at the top. By this scheme, the GF accepts full responsibility only for its operational performance at the bottom level, while results at the top levels of the framework, such as the impact on the diseases, are "increasingly due to the collective effort of other partners" in addition to the GF (IEG 2012, p.16). In this scheme it is left unclear how to measure the overall contribution from other partners and/or national governments to the impact area on top of the pyramid, and where to draw a 'demarcation line' between results attributed to GF contributions and other, non-GF contributions, making it difficult to distinguish GF-supported interventions. Chapter 5 discusses this scheme in the context of Ukraine where the difficulty of identifying GF-attributable HIV services presented one of the limitations for my study.

For each dimension of the performance management framework, the GF identified Key Performance Indicators (KPIs). The Policy and Strategy Committee of

the GF Board[24] develops and approves the KPIs, with baselines and targets, which are periodically updated. In 2011, there were 26 KPIs, 15 of which measured operational performance, and a large number of sub-indicators, most of which were also output indicators[25].The list of Top Ten GF performance indicators for 2011 is provided in Appendix A.

Fulfilment of KPIs by PRs is the main condition for continued funding. However, there are no specific rules in-country as to which indicators should be chosen. Under the country ownership principle, the choice of "their own performance indicators and target goals" is left to countries themselves (Glassman et al 2013, p. 46). The KPIs in each country are selected from the general GF list and agreed by the GF Secretariat and PR, and then incorporated into the grant agreement.

The World Bank IEG analysed the M&E systems of the GF. Describing the indicators relating to outcomes and impacts as "difficult to report", it noted that the GF performance indicators "provided little added value for assessing project/grant performance, for contributing to periodic summative evaluations, or for enhancing policy dialogue" (IEG, the World Bank 2012, p. 50).

The way the particular indicators are chosen, and the way to quantify them, as chosen by the recipients, may hold a potential for manipulation. First, performance indicators may not always capture all the goals that programs need to pursue. Secondly, if recipients are allowed to set their own targets, they may set unambitious ones simply to ensure that they can easily fulfil or over-fulfil these. Drew (2005e) expressed reservations about target setting associated with PBF. He suggested that agreeing targets between PR and GF could result in a "must achieve 100% mini project", a "negotiated agreement of what is needed and feasible within the time available" as, in his view, GF PBF system allowed for this kind of thinking. The outcome may be that the PRs "*that understand how the process works* will find it in their interest *to set low targets to ensure they achieve higher scores* in their grant performance report" (2005e, p.31). [emphasis added]

[24]The Committee abolished after the GF 2012 reforms.
[25]The web-link to KPIs at the Global Fund web-site was no longer accessible at the time of writing. Secondary data from the Center for Global Development report (CGD, 2013b) were used.

Thirdly, if funding decisions are dependent on performance indicators, another way to fulfil them is to direct funds toward organisations in higher-capacity areas, where results can be achieved more easily, and be easily measured. This may deprive the less developed or least accessible areas of money and services. Furthermore, in cases of a narrowly composed CCM, with its membership representing only a small circle of interested NGOs and government stakeholders, the potential exists of them agreeing on pre-determined goals in order to get funding.

A World Bank IEG report concluded that, while "the scale at which the Global Fund had attempted to implement PBF was unprecedented", the focus on results remained "a work in progress" and was "a complex and burdensome system … focused more on project inputs and outputs than on development outcomes and impacts" (IEG, the World Bank 2012, p. 46).

The Five-Year GF Evaluation noted lack of available standardized information for service delivery indicators across the GF grant portfolio (MACRO International 2007). Others spoke of a "superficiality of numbers that the Global Fund proudly announces as its 'results'" (Decosas 2012). Verification and measurement were also of concern to the CDG 2013 report that calls the GF to "immediately strengthen its verification of PR performance through a more robust approach to the measurement of the quantity and – where feasible – quality of health services delivered with Global Fund support" (Glassman et al 2013, p. 84). The CGD report concluded that the GF has not yet realized the full potential of performance-based funding and lacks "clear and consistent criteria for allocation" (ibid., p.46). More discussion of the potential benefits and challenges associated with PBF can be found in (Adam and Gunning 2002; Eichler 2006; Kerouedan 2010; Feachem 2011; Glassman et al 2013) and others.

1.6.5 The Office of the Inspector General (OIG)

The Office of the Inspector General (OIG) is the main structure within the GF for protecting its operations from fraud and the misuse of funds. The need for an independent auditing structure inside the GF was articulated by the U.S. Congress resolution that followed from a CRS report (CRS 2005). Established in December 2005, the OIG operates as an independent unit of the GF, reporting directly to the

Board (GFATM, n.d.3). OIG audit teams are multi-disciplinary and combine financial auditors, public health experts and procurement specialists (Linnee 2010).

The OIG structure enjoyed relative obscurity within the GF's generally frequent and vocal public relations campaigns and press releases. It came up strongly in 2008 when John Parsons, a British citizen who previously worked at UNESCO and UNICEF and also headed the UK National Audit Office in 1989-1996 (Heilprin 2012), was appointed as the GF Inspector General. In that year, the OIG released a series of reports about previous GF grant suspensions. These reports were critical of the internal management systems at the GF Secretariat level, as a result of which "not sufficiently robust systems were built on the ground … and Principal Recipients management systems were often faulty" (Heilprin 2012). The OIG's mandate covers audits and investigations of fraud allegations, including those from whistleblowers. As noted by AIDSPAN, from 2008 to 2009, the number of investigations stemming from whistleblower complaints tripled under Parsons."We don't just look at the financial inputs; we look at what has actually been achieved," Parsons said, explaining that the audits are aimed at giving assurance that the GF grants "are used wisely to save lives"(Cited in Linnee 2010).

In his tenure as the GF Inspector General, Parsons was continuously at odds with the then GF Executive Director Michel Kazatchkine, which was reported by various sources (McNeil 2012; Garrett, 2012). In particular, the focus of criticisms of Parsons' work was that his reports intended to cover not only the financial management, but also looked at programmatic aspects of GF grants and that angered some NGOs (Rivers 2012). Parson's office was active in conducting investigations, and Kazatchkine's office acknowledged that if Parson's office doubled the amount of programs it reviewed, then "the amount of losses identified may also double"(Heilprin, 2011a).

In 2009, at the onset of the world economic crisis, UNAIDS warned of the impact of the crisis on HIV prevention and treatment programmes suggesting that "the HIV and AIDS response has reached a turning point" (UNAIDS 2009b, p. 5). An even bigger threat to global HIV/AIDS response, however, came from the Global Fund itself.

1.7 The Global Fund crisis in 2011

"awful moment in the Fund's history"(Garrett 2012)

At the 22nd GF Board Meeting in Sofia, Bulgaria, on 13-15 December 2010, a document, 'Secretariat Response to Findings of the OIG and Joint Communication on Inspector General Matters', was disseminated. It commented on issues of concern over the results of OIG audits in several countries:

> The Secretariat and the Inspector General have agreed that it is important that cases of fraud, financial abuse and misappropriation are put in their proper context. Given the large number of countries, and the extreme variations in governance and management capacity across the GF portfolio, the Secretariat and the OIG agree that the *OIG's findings in particular cases should not be used to draw general conclusions across all grant-programs or about the Global Fund*. OIG findings in particular cases should not be interpreted as calling into question the basic principles underlying the work of the Global Fund, or its general model.(GFATM 2010) [emphasis added]

On January 23, 2011, the AP released an article that discussed instances of corruption discovered by the OIG (Heilprin 2011a). The article focused on allegations of corruption and fraud in four countries that received GF grants - Mali, Djibouti, Mauritania and Zambia. The article cited findings of the OIG office that up to two-thirds of the funds in some of the GF grants reviewed were lost to fraud.

In response to the AP article, on January 24, 2011, the GF issued a statement defending its record and commitment to transparency:

> The Global Fund has zero tolerance for corruption and actively seeks to uncover any evidence of misuse of its funds. It deploys some of the most rigorous procedures to detect fraud and fight corruption of any organization financing development.. The news report that has caused concerns refers to well-known incidents that have been reported by the Global Fund and acted on last year. (cited in Kaiser Family Foundation 2011)

Jon Liden, the GF communications director, in an interview with the DevEx news service called the controversy surrounding his organisation "a grave misunderstanding". When answering a question on whether this was a wake-up call for the GF that it needed to tighten its monitoring of how grant money was used, Liden answered, "Not really" (Taylor 2011).

These statements triggered a wave of criticism from other agencies, which felt the Fund was attempting to divert attention from itself. Reactions followed from critics and supporters of the GF about corruption in foreign aid in general and the Fund's response to corruption in particular, including the perspective of the newly elected U.S. Congress "to hold hearings concerning halting aid dispersion to the Fund"(Bate 2011). The media revelations resulted in much closer scrutiny of the GF's work, and a drop in its funding, prompting Germany, the European Commission (EC), and Denmark to withhold $457 million (Euro 315 million) in funding (Heilprin 2011b). Sweden, the fund's 11th highest contributor, also suspended its annual donation.

On February 8, 2011, the GF released a statement by the Board Chair and Vice-Chair saying that it had instituted several measures "to reinforce its financial safeguards and increase its capacity to prevent and detect fraud and misuse in its grants" (cited in Salaam-Blyther 2011, p. 8). The GF has also doubled the budget of the OIG (Economist 2011) and organised a number of trips for journalists to observe GF-supported programs in six different countries (GFATM 2011).

Later, however, the GF Board considered scaling back investigations and releasing less information about them publicly and to donors. The Inspector General Parsons publicly opposed these changes since he believed that this "could be interpreted negatively and as a purposeful effort to suppress material information". Although the GF characterised the media coverage as exaggerated and "wildly inaccurate and misleading", similar concerns were expressed in the U.S. Congress (Heilprin 2011b).

Addressing the U.S. House of Representatives, U.S. Global AIDS Coordinator Eric Goosby spoke of the need "to support and strengthen the Fund's efforts to root out corruption in its grants, supporting a strong and independent Inspector General and working to protect both U.S. taxpayers and the people who rely upon the health programs financed through the Fund"(US House of Representatives 2011, p. 7).

On April 5, 2011, the U.S. Senate Foreign Relations Committee released a minority report, containing recommendations on how to strengthen the oversight of GF grants (US Senate 2011), among them the following:

- Make U.S. contributions to the GF contingent upon the GF Board's adoption of reforms laid out by the U.S. Department of State.
- Have the U.S. Representative to the GF reiterate in the strongest terms to the GF Board that the US has no tolerance for fraud and abuse and that the OIG needs to acquire adequate resources and personnel to audit and investigate programs on the ground.
- Have the GF take any steps necessary to ensure that LFAs and CCMs are capable of managing grants and are properly trained on how to spot and mitigate suspected fraudulent activities.

On March 16, 2011, the GF announced that the former Secretary of the U.S. Department of Health and Human Services, Michael Leavitt, and the former President of Botswana, Festus Mogae, would lead a high-level panel of international experts to review and reform GF systems (CRS 2011). The head of the High-Level Panel was Gabriel Jaramillo who later became a GF General Manager.

On September 9, 2011, the High-Level Panel Review was released. It acknowledged the GF oversight systems were 'imperfect' and stressed the need for Fund to get over the 'unpleasant' period:

> The controversy surrounding the audit and investigative reports released by the OIG in the last six months has, in large measure, diverted the attention of the Global Fund's Board and management. While the Global Fund can never tolerate dishonesty, and sub-standard performance is always disappointing, it is important to view certain aspects of these reports in their historical context. The early years of the Global Fund's life were a period during which the institution went from a standing start to deploying resources quickly in dozens of countries at the same time, in response to an evident worldwide emergency. Donors and recipients felt the urgency. *Goals and expectations were unclear, and oversight mechanisms imperfect.* (GFATM 2011a, p. 61) [emphasis added]

The Panel Review stressed that the GF Board, Secretariat and the OIG should all agree to a 'Turning of the Page,' a reconciliation strategy, faithful to the Fund's founding principles, which would involve the following elements:

- No amnesty for fraud, but focus oversight on more recent rounds of grants. The GF oversight mechanisms should look to the future, focused on Rounds 6 (2007) and afterwards.
- Strengthen the relationship between the Secretariat and the Inspector General.
- Adopt a new risk-management framework
- Redefine 'Country ownership' in the context of the Global Fund's risk-management framework (GFATM 2011a).

Meanwhile, at the May 2011 Board meeting, the OIG presented its vision of what was important for the GF, which included:

- Reconsider the relevance of the GF's model. The Fund should reconsider whether to remain just a financing institution, reliant upon national ownership. If the Board decided to retain that model, the OIG recommended identifying other options to mitigate the risks of fraud and financial misappropriation.
- Reevaluating the KPI structure. The OIG asserted that the KPI structure's emphasis on speed and quantity of disbursements often compromises quality and adequate consideration of risks.
- Establishing minimum acceptable capacity standards to assess PRs and develop a system to hold PRs accountable when things go wrong.
- Enforce the policies and guidelines that have not been implemented at country level.
- Making CCMs more effective in their oversight duties, and ensuring that they are without conflicts of interest (OIG 2011, pp. 8-9).

The OIG suggestions resonate with much of the critique about GF systems and policies discussed above.

The U.S. issued a 'Call to Action for reform', launching a process to improve the Fund's operations, especially at the country level. This statement was embraced

at the GF Board meeting in November 2012, and a Reform Working Group was established to push this reform agenda forward as a top priority (US House of Representatives 2011).

At the same meeting on November 15, 2012, the GF Board fired John Parsons from his post as Inspector General on the grounds of "unsatisfactory performance"(GFATM 2012d). This decision was criticized by many organisations. The US-based AIDS Healthcare Fund (AHF) called it a 'hatchet job' and a very dark day for the GF and accountability in development funding in general. AHF President Michael Weinstein said, "It appears that John Parsons has been fired merely for doing his job too well" (AHF 2012). The decision to fire Parsons came despite the fact that the High-Level Review Panel expressed "enormous respect for the positive impact the OIG's work has had on securing the organization's investments" and called the OIG "the only risk-mitigation strategy within the Global Fund that has worked as designed"(High-Level Panel, p.53).

1.8 Changes in the GF after 2012. The New Funding Model (NFM)

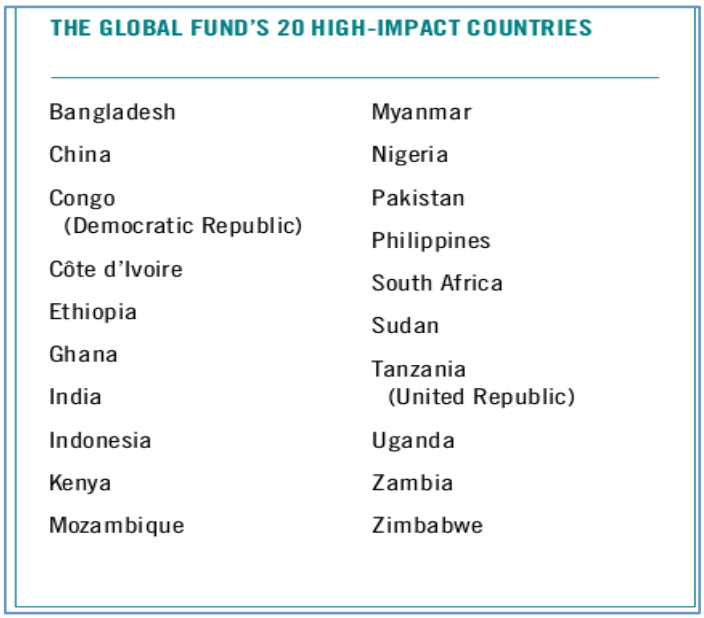
In November 2011, the GF Board approved a new strategic plan "to become more flexible, iterative and better-informed" in order to increase the impact of its programmes. As part of that process, the GF introduced the New Funding Model (NFM), which replaced the existing rounds-based system. Access to funding in the transition phase was by invitation, and special consideration was to be given to countries in a position to achieve rapid impact, those at risk of service interruptions, and those currently receiving less than they would under the new funding model's allocation principles (GFATM 2013c).

An editorial published in *The Lancet* warned: "The continued survival of the Fund remains at risk. The organisation is still in a period of transition. It needs to enter a phase of stabilization" (The future of the Global Fund 2012, p. 860).

In 2012, the GF spoke about "refocusing resources" and suggested that in order to achieve the most impact on the epidemic, funding should be concentrated "in the countries where the GF and partners can have the greatest impact. These 20

countries account for more than 70 percent of the global burden of HIV, TB and malaria" (GFATM 2012b, p.11):

Figure 1.7 The Global Fund 20 'High Impact' Countries



Despite being presented as a more predictable funding opportunity (GFATM 2012b), the NFM brings uncertainties as to how it will ensure the GF core principles of demand-driven and country-owned responses to the three diseases. While UNAIDS described the NFM's focus as supporting "the countries with the most serious epidemics and least ability to pay" (UNAIDS 2013), Glassman et al. (2013) noted that a new regional GF focus would disqualify middle-income countries from accessing GF funding at the time when the global disease burden was shifting more towards them.

On January 22, 2013, the GF Executive Director Mark Dybul addressed a global health conference in Oslo. He stressed:

> We need to move past the tyranny of averages. We all see country and regional average rates of HIV, TB and malaria, but they mask micro-hyper-epidemics where transmission rates are very high. A *micro-hyper epidemic* is an outbreak of disease that is *highly concentrated* among a part of the population, putting a wider population at risk of infection. By focusing high-impact interventions where new infections are occurring, countries will *get the biggest bang for the buck.* (GFATM 2013e) [emphasis added]

This statement suggests a further narrowing of the scope of GF-supported interventions, as well as the GF narrowing its 'responsibility zone'. The GF new deliberation, manifested clearly through the NFM, makes the question of whether it coalesces with the country ownership principle that GF programs "reflect national ownership and respect country-led formulation and implementation processes" (GFATM 2001), essentially rhetorical.

Conclusion

This chapter began with a discussion of the global governance models proposed by Savedoff (2012). At the end of his paper, he concludes that:

> Mixed coalitions have been able to achieve a lot without being able to compel uniform action. The tragedy of this limitation, though, is the painful gap between what we accomplish and what we could accomplish.. So, mixed coalitions are a form of international self-organization that are promising and problematic. There is no guarantee that they will form to address the most important issues and no guarantee that any particular coalition or team will have the resources—financial or in legitimacy—to carry out important functions. (Savedoff2012, p. 16)

The GF continues to evolve at the time of writing. Since most of the data collection and literature analysis occurred before the start of GF 2012 reforms, the analysis and the discussion presented in this thesis focus on the structures and policies that existed at the GF prior to that. While every possible effort has been made to present literature updates and new GF-related data as it became available closer to the time of completing writing, it was not possible to incorporate all of the new information into analysis. However, the author believes that the now historical character of many of the described events does not diminish the importance of this enquiry, but is a reminder that "the Global Fund has been and still is very influential in shaping major international health policy choices that warrant serious scrutiny from the global health community" (Italian Global Health Watch 2008, p.47).

CHAPTER 2. UKRAINE: HISTORY, POST-SOVIET TRANSITIONS AND HIV EPIDEMIC. THE GLOBAL FUND ENTRY TO UKRAINE.

2.1 Country background

2.1.1 History of Ukraine: a divided country.

Ukraine is the second largest country in Europe with an area of 603,628 sq. km. The capital of Ukraine is Kyiv, with a population over three million. Administratively, the country is divided into 24 provinces (*oblasts)*, one autonomous republic of Crimea, and two cities with a special status: Kyiv and Sevastopol (Ukraine, 2011). After the dissolution of the USSR, Ukraine has been rapidly depopulating: its population fell from 52 million in 1991 to an estimated 44,573,205 in July 2013 (CIA World Factbook). With one of the lowest birth rates in Europe, Ukraine's crude death rate is 15.75 deaths per 1,000 population - second only after South Africa (ibid.).

Figure 2.1. Map of Ukraine

Ukraine was not always known by its present name, although it has a very ancient and rich history and a highly developed national identity and culture. Its relative

obscurity originates from the fact that Ukraine, for most of its history, was a divided nation, and moreover, a stateless one. For centuries, Ukraine was divided among countries with different political, religious and social systems.

The first historically known state on Ukrainian territory was a Slavic state, Kievan Rus'. Centered in Kyiv, it prospered on trade between the Baltic and the Mediterranean Seas. The Rus' reached its 'Golden Age' in the 10th-11th centuries during the reigns of Vladimir the Great and his son Yaroslav the Wise. In 1240, weakened by internal feuds, Kyiv was invaded and devastated by Batu (Batyi), the grandson of Genghis Khan. Subsequently, the Rus fell in decline and came under the influence of Polish-Lithuanian, Mongol and Cossack (*Zaporizhya Sich*) states, while a new entity in the north, the Muscovy, began to gain influence, forming the basis for the future Russian Empire (Fennell, 1983). After the 1686 'Eternal Peace' treaty with Poland, Ukraine was divided – *pravoberezhna* (right-bank) Ukraine, west of the Dnieper, went to Poland and *livoberezhna* (left-bank) Ukraine, east of the Dnieper, and Kyiv went to Russia. The formal partitioning of the two regions made the Dnieper a frontier zone which it remained for more than a hundred years. By the Third Partition of Poland (1795), right-bank Ukraine was also annexed by the Russian Empire.

Halychyna, or Galicija, also known as Western Ukraine, was situated further west from right-bank Ukraine on territories now occupied by Lviv, Ternopil and Ivano-Frankivsk oblasts, and developed as a distinct entity. Its population is believed to descend from a West Slavic tribe called White Croats that was part of the Great Moravia state in Central Europe in the 9th century (Spiesz, 2006). Between 12th and 16th centuries, control over the area passed from Hungary to the Polish-Lithuanian Commonwealth. In 1772, Halychyna became a province of the Austrian-Hungarian Empire. After the end of WWI and collapse of Austrian and Russian empires, and the 1917 revolution in Russia, several short-lived independent states emerged across Ukraine. Eastern Ukraine was incorporated into the USSR after 1921, and Halychyna became part of Poland. In 1939, Halychyna became part of the Soviet Union, following the infamous Molotov-Ribbentrop pact between Germany and USSR, and was invaded by Germany in 1941. Before the war, Halychyna was a prominent center of European Judaism, with an estimated Jewish population of 530,000. At

least 520,000 were murdered during the Nazi occupation, before the region was liberated by the Red Army in 1944 (Interactive, n.d.).

Crimea historically was under control of the Crimean Khanate. Later disputed by Turkey and Russia, including the 19th century Crimean War, it eventually became territory of the Russian Empire. Crimea is home to a significant Muslim minority, the Crimean Tartars who constitute 12% of Crimea's population (Ukrainian Census 2001), as well as other nationalities (Greeks, Bulgarians, Krymchaks). Crimea was a battleground in several wars, including WWII and the bitter Red Army defense of Sevastopol. Crimea was a popular Soviet resort, particularly known for its tuberculosis treatment sanatoriums. In 1992, Crimea became turbulent when the Crimean Parliament adopted the Act on State Independence of Crimea (Mizrokhi, 2009). Fearing the spread of separatism in former Soviet republics, Presidents Kravchuk of Ukraine and Yeltsin of Russia divided the ex-Soviet Black Sea Fleet based in Sevastopol and agreed to autonomy for Crimea under Ukrainian jurisdiction.

2.1.2 Economy: agrarian versus industrial Ukraine. Regionalism

For centuries, Ukraine was a granary of the Russian Empire (Aslund, 2009), and is often called 'a bread basket of Europe' because of its abundant black soils (*chernozems)* that are among the most fertile soils known (Britannica, Encyclopaedia). Ukraine suffered severely during Soviet collectivisation of agriculture in the 1930s. Five to seven million people are believed to have died in an artificially imposed starvation – *Holodomor* - or Hunger Death (Aslund, 2009), while almost 30 million tons of grain were exported in 1932-33 to world markets to finance Stalin's industrialisation plans (The Ukrainian Museum, 2003).

After WWII, Ukraine developed into a strategically important region, with a strong emphasis on the military-industrial complex and heavy industry, defense-oriented science and technology development. Its fertile black soils generated more than one-fourth of Soviet agricultural output (CIA World Factbook, 2012). Ukraine was a strong asset of the former USSR. Ukrainian economy was developing along the regional divides - heavy and military industry and manufacturing were concentrated in Eastern Ukraine, whereas Western Ukraine was more agricultural.

After the end of the USSR, Ukraine was initially viewed as a country with favourable economic conditions in comparison to the other republics. However, its economy remained dependent on energy supplies from Russia, which has been using Ukraine's dependency as a foreign policy tool (Balmaceda 2008).

Ukraine cannot be understood without acknowledging its "regional peculiarities and tensions" (Aslund 2009, p. 19). Ukraine's regions played an important role in the formation of the Soviet political elites. Soviet leaders Khruschev and Brezhnev as well as many prominent Politburo and military elite members - came from Ukraine.

Ukrainian regionalism is sometimes presented as the outcome of the weak role of the country's capital, Kyiv, versus more influential regions. Aslund (2009) suggests that, unlike many other European countries, Ukraine - in its modern history - was never dominated by its capital. Instead, in Soviet times, Dnipropetrovsk – the industrial powerbase in Eastern Ukraine – was the leading light – and produced Communist leaders Leonid Brezhnev, Volodymyr Shcherbytsky, and after independence in1991, the second President of Ukraine Leonid Kuchma, as well as prime ministers Pavlo Lazarenko and Yulia Tymoshenko. So many political elites, as well as prominent Soviet sports, science, and arts figures originated from the city that it became common to talk about the 'Dniepropetrovsk clan' (Schmidt-Häuer, 1986), exerting influence on the life of the whole USSR. Donetsk, the other industrially developed region and a base of coal production, produced President Victor Yanukovych as well as the richest man in Ukraine Rinat Akhmetov (Forbes, 2012). Together, Donetsk and Dniepropetrovsk oblasts represented the industrial wealth of Ukraine and after 1991 became the seats of the wealthiest business empires (Aslund, 2009).

Dniepropetrovsk native Volodymyr Shcherbytsky whom Brezhnev appointed as the first Secretary of Communist Party of Ukraine (CPU) in 1972, was characterized as a 'hard-liner' and a 'Brezhnevite' because of his stronghold over the party apparatus and loyalty to Moscow. Considered by many as a possible successor to Brezhnev as a head of the Communist Party of the Soviet Union, Shcherbytsky supported centralisation of the Ukrainian economy and was a harsh opponent of

nationalist dissent (Subtelny, 2009). Shcherbytsky remained at his post until 1989, long after other Brezhnevites lost power (Aslund, 2009). Few of Gorbachev's new policies of *perestroika*, *demokratizaciya* and *glasnost* (restructuring, democratization and openness) were implemented in Ukraine where they were viewed as strange phenomena, shown on TV from Moscow. A popular joke of the time was, 'If you want a break from *perestroika*, come to Ukraine.'

2.1.3 Chernobyl, perestroika and the end of the Soviet Union

On 26 April 1986, the most severe nuclear accident in history occurred at the Chernobyl nuclear power plant, 60 miles north of Kyiv, releasing large amounts of radioactive fallout. Handling of the accident by authorities exposed the deeply cynical character of the regime - as members of the government commission observed the Chernobyl liquidation work from a sealed bunker, fire brigades, especially in the first hours of the catastrophe, extinguished radio-active fires without any protection gear(Grogan, 1987). As news of the accident spread, authorities held the usual May Day parade in Kyiv, despite worries of high levels of radiation, while the Ministry of Health (MOH) released reassurances about 'safety'. The parade included children engaged in dancing and sports activities. The conduct of the May Day parade, and a bicycle tournament held in Kyiv the following day, were a shocking demonstration of how far the officials could go to conceal information about the Chernobyl accident. Under pressure from abroad, Moscow authorities released limited information about the accident several days after it happened (Rubin, 1987), while the MOH said that 'a certain amount of radiation is good for you.'

Chernobyl was the first hard challenge for the General Secretary of the Communist Party of the Soviet Union Mikhail Gorbachev. With popular sentiment rising against a stagnating economy, food shortages, and lack of political freedoms, the way Chernobyl was handled by authorities was deeply upsetting to people who had not been informed about the disaster (Aslund, 2009). The Chernobyl accident and clumsy dealing with safety information by Soviet authorities left a strong legacy behind and catalyzed anti-Soviet tendencies. As Gorbachev himself acknowledged,

“the nuclear meltdown at Chernobyl, even more than my launch of perestroika, was perhaps the real cause of the collapse of the Soviet Union”(Gorbachev, 2006).

While there was much talk about reform, Gorbachev's policy of *perestroika* was never introduced into practice for the majority of citizens (Magocsi, 1996). About 95 percent of industry and agriculture was still owned by the Soviet state in 1990. Distrust and disillusionment with the regime were growing. A very unpopular war in Afghanistan was also costing the Soviet Union dearly. A well-intended and reputedly effective anti-alcohol campaign, initiated by Gorbachev (Bhattacharya et al, 2012), was perceived negatively by the public. It triggered a massive surge in illegal alcohol production and dealt a fatal blow to Gorbachev’s popularity (Reuters, 2009).

After an infamous August 1991 coup, a last-ditch effort by party hard-liners to maintain the USSR, disintegration processes in the former Soviet republics accelerated, led by republican Communist apparatchiks and democracy movements. The Baltic republics of Latvia, Lithuania and Estonia were the first to leave the USSR. The process culminated in signing of the Byelovezh Treaty (named after a forest reserve in Belarus) by Russia’s President Boris Yeltsin, Belarusian Supreme Soviet Chairman Stanislav Shushkevich, and Ukraine’s Supreme Soviet Chairman Leonid Kravchuk on December 8, 1991. The document proclaimed the end of the Soviet Union as a subject of international law, and agreed to the establishment of the Commonwealth of Independent States (CIS), to be composed of the 12 republics that still made up the Soviet Union at the time (Pifer, 2011). The sidelined Gorbachev was forced to resign on December 25, 1991.

2.1.4 Ramifications for a new Ukraine: from communism to oligarchy

Ukraine entered the post-Soviet era through a negotiated pact between the national communist officials and national democrats (Kuzio, 2000). To most members of the former Communist governing apparatus (*nomenklatura*), Ukraine’s independence emerged as an unanticipated by-product of the collapsed center in Moscow. The main stake holders in Ukraine’s political formation were the former *nomenklatura* and the ‘red directors’ – former Soviet industry managers who were quick to realize that “the state was the most lucrative feeding ground” (Zon 2000, p.10), where they could “best pursue their individual and group interests”(Narozhna,

2002), so they "moved from being directors of enterprises to owners of enterprises they once controlled"(Shelley, 1998, p.653). In addition to communists and 'red directors', the state formation of independent Ukraine has been shaped by a popular National-Democratic 'Rukh' Coalition. As none of those three groups were powerful enough to rule by themselves, their alliance formed a basis for establishing a political system in Ukraine. After consolidation of industrial and financial groups and the formation of oligarchy, the initial tri-partite alliance dissolved and its members aligned with different oligarchic groups.

In Ukraine, as in other post-Soviet states, the transition to a market economy was "beneficial only to a privileged few and not accompanied by the establishment of the rule of law" (Barkowski 2011, p. 2). Earlier research on Ukraine suggested the central role of a 'criminal-political nexus' - the alliance of the former party elite, members of the law enforcement and security apparatuses, and organized criminals who together penetrated the licit and illicit sectors - during privatization (Shelley, 1998). Some authors (Millar 1996; Wedel 2001 and others) have attributed a significant share of the responsibility for creating the conditions that led to the 'Great Grab' (Wedel 2001) – a *de facto* theft of state assets by red directors and oligarchs - to US aid programmes led by Jeffrey Sachs and his colleagues at the Harvard Institute for International Development, as noted above.

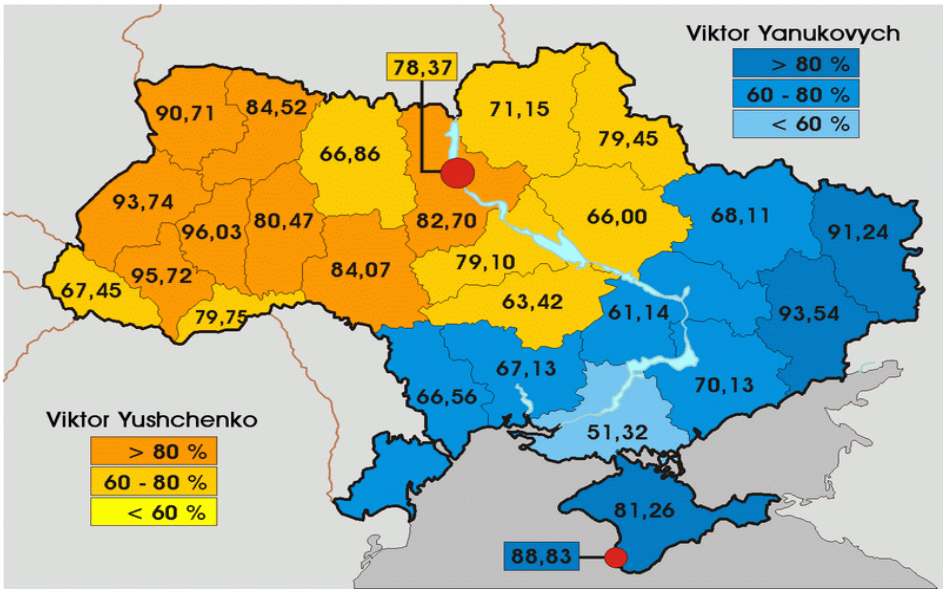
Political splits began to take shape according to historic regional divides that presented two broad foreign policy options. Those who preferred a 'Slavic choice' – closer ties with Russia and the other FSU countries – lived predominantly in Eastern Ukraine, southern oblasts, and Crimea. The 'pro-Western' or 'pro-European' direction was supported by staunch defenders of Ukrainian sovereignty, in particular its independence from Russia, who tended to predominate in the center, including Kyiv, and Western Ukraine. In modern Ukraine, most political parties' programmes continue to operate along this dichotomy (O'Loughlin, N.D.). As one Western diplomat noted, "No one can say what is happening in Ukraine, or where the country as a whole is heading because no one can grasp the country as a whole. The different areas are totally different" (cited in Lieven 1999, p. 79).

In particular, Dnipropetrovsk-clan representative Leonid Kuchma's tenure as president (1994-2005) was problematic. "Growing paralysis in decision-making in the legislature and the rising encroachment of the patrimonial state and the oligarchs, has increased the power of vested interests over the State"(ILO 2001, p. 9). Under Kuchma, the vested interests had grown so strong that they were almost invincible. A year-long tenure (1996-97) as prime minister of notorious Pavlo Lazarenko from Dnipropetrovsk, appointed by Kuchma, became "the epitome of corruption" (Aslund 2009,p.95)[26]. In other parts of Ukraine, where many industries and collective farms were downsized or closed, discontent grew over lack of economic opportunities, unemployment, and the wide-spread corruption, associated with Kuchma's regime.

The murder of investigative journalist Georgy Gongadze, whose beheaded body was found near Kyiv in 2000, ignited a major political crisis that erupted when allegations emerged that Kuchma, and his presidential administration, may have ordered the killing (Institute, 2001; Penketh, 2001). Mass rallies followed across Ukraine, and anti-Kuchma political forces gained momentum and significant popular support. In 2004, Kuchma's attempt to secure his power by nominating a Donetsk-clan representative, Viktor Yanukovych to run for president, was marred by massive fraud in the second round of elections, and culminated with the 'Orange Revolution' in November 2004. Ukraine's regional divides were a visible factor in the 'Orange Revolution':

Figure 2.2 Regional vote distribution in the 'Orange Revolution' (Wikipedia, n.d.)

[26] In 1999, Lazarenko fled abroad and was detained and imprisoned in the US for money laundering. He is on Top 10 most corrupt leaders in recent history list, together with Philippines President Marcos and Indonesia's Suharto (Zaheer, 2011).



The victory of 'pro-Western,' allegedly reformist Viktor Yushchenko was claimed by voters from Western and central Ukraine, while Eastern Ukraine predominantly supported Viktor Yanukovych.

Despite widely held hopes that the 'Orange Revolution' was Ukraine's democratic breakthrough, some cautioned against representing it as the establishment of liberal democracy (D'Anieri, 2007). The post-Orange Revolution period and Yushchenko presidency (2005-2010) were characterized by great domestic political instability (Peterson Institute, 2009), exacerbated by the onset of the world economic crisis. Despite their harsh revolutionary rhetoric, Yushchenko and the Orange leadership did not succeed in eliminating the rent-seeking oligarchic network (Fischer et al, 2008). One of the Orange leaders, Yulia Tymoshenko,[27] lost 2010 presidential elections to Viktor Yanukovych and was imprisoned on charges of abuse of power.

2.1.5 Ukraine on the 'Chessboard': 'Europe's Linchpin' and a large aid recipient

After 1991, Ukraine became a recipient of massive foreign aid to support democracy, structural adjustment and promoting reform. As noted above, an important shift was that from an aid giver – the USSR provided massive aid to

[27]A native of Dnipropetrovsk, Tymoshenko became known as the "Gas Princess' in the 1990s, when as the protégé of former Prime Minister Lazarenko, she headed Unified Energy Systems (UES), the company importing Russian gas into Ukraine. Her career in the gas industry is believed to have allowed her to amass a fortune (AlJazeera 2011).

developing countries in par with the USA (Rivero, 2009) – to a recipient of massive foreign aid. Not only there was no institutional background for absorbing aid coming in large amounts, but soon it became obvious that different donors were promoting different reforms in different states. In *Collision and Collusion*, Janine Wedel talks about how the donors distinguished between different FSU countries: 'more developed' states were those with nuclear arms, while ethnically troubled Uzbekistan, Kyrghyzstan, Kazakhstan and Caucasian republics fell into the domain of 'underdeveloped' (Wedel 2001, p. 20). Ukraine, as 'more developed', received significant initial aid for de-nuclearization and disarmament (Narozhna, 2002). Throughout the 1990s, it was the third largest global recipient of US aid (Perlez, 1996). Borodchuk (2012) described foreign aid strategies in Ukraine as mostly *ad hoc*, based on political momentum. According to a local think tank,Geostrategy, from 1990 through 2011, Ukraine received $3.336 billion in aid (Rosbalt Ukraina, 2011).

Aid earmarked for Ukraine was not just for its disarmament. Some in the Western political and scholarly establishment adopted the 'Chessboard' concept (Brzezinski, 1997) in Ukraine's post-independence years, viewing it as 'Europe's Linchpin,' which should play an important role in the stability of the region and whose statehood should be preserved by all costs:

> An independent, democratic, and reform-oriented Ukraine can provide a model for Russia's development ... and promote stability in Central and Eastern Europe... Ukraine needs Western money and diplomatic backing to preserve its independence and keep reform on track. A civil war between its Russified east and its more Ukrainian west, or its absorption into a new Russian empire, would reverberate throughout Europe. (Mroz and Pavliuk, 1996)

In this externally assigned role, the country is supposed to both counter-balance Russia and serve as a model for Russia's development. Despite the lack of consistency and strategic perspective, foreign donors and the international community continued to view Ukraine through the 'Russia prism' which caused "considerable frustration in Kyiv" (Fischer 2008, p. 15). The persistence of Western hopes that Ukraine would grow into this role may help explain why, for so many years, despite little in the way of meaningful reform, this post-communist country was so favored with aid. Some types of programmes were particularly promoted.

'Democracy promotion': a focus on NGOs

As time passed after independence, concerns over its 'democratic regression' disturbed prior assumptions that Ukraine "was on a 'transition' path to a consolidated democracy" (Kuzio 2005, p.167). The West became concerned about a dysfunctional state, manifested by its inability to satisfy the basic material needs of the population, or to determine a comprehensive reform strategy (Wolowski, 2009). Support for civil society looked particularly attractive, "crucial to the post-communist political transformation and a panacea for problems from corruption and lack of accountability to service delivery needs" (Lopes 2012, p. 1).

While support to local NGOs was a "talisman of international development organisations"(Atlani-Duault 2007, p. 14), support for civil society in the post-communist world was particularly high on aid agencies' agenda. Henderson (2003) noted a shift in Western countries' political agenda after the fall of communism. Having initially promoted economic and social development in the post-colonial developing world, they moved to directly 'promoting democracy' in post-communist states. This shift represented "a substantial foreign policy experiment" in which recipient countries were "laboratories of experimentation"(Henderson 2003, p. 3).

The number of NGOs in Ukraine mushroomed after independence and liberalisation of political freedoms. At the same time that Robert Putnam was observing that in America more people were "watching TV... and civic society has shrunk" (Putnam 1995, p. 65), in the early 1990s, public activism was at its height in post-Soviet republics[28]. The 1992 Law "On Citizen Associations" (E-Law, 1992) allowed thousands of citizens groups and initiatives to officially register. By 2011, about 50,000 different-sized NGOs and charity organisations were registered in Ukraine (Kondratenko, 2012). Official sources list 91,317 registered public associations of all forms (Ukrstat, 2013a). Ukraine was said to have "the freest and

[28] Early public associations grew out of public movements during perestroika and were mostly informal grass roots citizen groups, gathered around a particular cause or initiative, locally or nation-wide. Members included workers, academics, women, students, etc. who worked on a voluntary basis and supported organisations through membership fees, personal funds or local fundraising. Hundreds of such groups were a base of nascent post-communist civil society.

most vibrant civil society among CIS countries" where levels of civil society development "approximate the levels of new EU member states"(UNDP , 2007).

The political momentum for early post-Soviet civil society was short-lived. Just as the new NGOs began to acquire space and prominence, the political arena began to fill with 'transnational advocates' (Hrycak, 2007) – international NGOs (INGOs) – and their funders. The influx of foreign-funded NGOs to Ukraine and other FSU states occurred under the label of 'democracy building' (Carothers, 1999b). Zhukova (2013, p. 115) called this process a "promotion of soft imperialism" aiming at the decentralization of post-Communist states under the umbrella of democracy. The effort did not materialise in fruitful results, argue Carothers (1999b), Wedel (2001), Sampson (2003), Henderson (2003), Hrycak (2007), Fioramonti and Heinrich (2007), Pishchikova (2011), and others. In Ukraine, increasing contact with 'transnational advocates' led to "increased competition among similar groups for foreign funding", with local organisations devoting themselves "to the causes and concerns of foreign donors"(Hrycak 2007, p. 89), while NGO involvement began to be perceived as a job opportunity - 'office work'. This resulted in rapid formation of 'project society' and 'project elites':

> People within and outside organizations compete for money, influence, access and knowledge; they distribute these resources among their own networks and try to prevent others from obtaining access. The successful actors in this competition become the project elites... intimately tied to Western ideas and funding, not to mention knowledge of English and the set of skills associated with "project management". This Euro-elite is not only paid well ... [they] earn more money than their parents ever did, and more than high government officials. In this sense, they form part of a new comprador bourgeoisie (Sampson, 2003).

In FSU region, those were commonly referred to by a derogatory term *grantoedy* or *grantozhery* (grant-eaters), to describe organizations that know "how to apply for and obtain funds", but do not "bring change" (Shapovalova 2010, p.11). CSOs[29] in post-Soviet context are frequently described as "vertical organisations that do not respond to crucial societal concerns", "being more interested in pleasing foreign donors, than paying attention to what people need and what they say"

[29] In this research, the terms 'CSO – civil society organisation' and 'NGO – non-government organisation' – are used interchangeably because, although they are distinct notions, in the context of Ukraine they usually refer to the same entity. There has been a proliferation of various NGO terms, e.g. GONGO – Government organised NGO, and others (Götz 2008).

(Fioramonti and Heinrich 2007, p. 25), "parroting the phrases donors expect in order to win grants" (Hrycak 2011, p. 261), or "more firmly rooted in transnational networks than in their own societies" (Wedel 2001, p. 114). Pishchikova (2011), analyzing US aid to NGOs in Ukraine, argued that despite the dominance of the 'civil society assistance' discourse, the aid effect was often negative as it "fell short of the proclaimed goal of democracy-building, and impeded the development of indigenous civil society" (Pishchikova 2011, p. 198).

Transition from citizen initiated CSOs into *grantoedy* did not just happen overnight, but grew out of the post-communist political development. Political scientists observed that changes in the powers of Ukraine's president facilitated development of a culture of 'Neo-Patrimonialism' (Van Zon, 2005), based on a 'delegative democracy' (Kuzio, 2005), manifested during Kuchma's second term (2000-2004), as well as after the 'Orange revolution' during Yuschenko's presidency (2005-2010). The president positioned himself as having directly delegated powers from the people who voted for him, which precluded the need for people to be represented by civil society institutions. The main feature of neo-patrimonialism is "the private appropriation of the public realm" when public and private spheres are "*de jure* separated but *de facto* such separation does not exist" (Malygina 2010, p. 10). This model was characterised by low levels of political participation beyond voting. In fragile post-communist political organisms, the combination of neo-patrimonialism in the domestic political sphere and an influx of INGOs worked to sideline *bona fide* grass roots organizations, and replace them with "puppet organisations that appear to be civic structures" (Kondratenko, 2012).

While Malygina (2010) observes how neo-patrimonialism facilitated the state officials' use of public resources to acquire wealth, Kondratenko (2012) suggests that foreign-funded CSOs were also viewed by bureaucrats as a source of income. "Not uncommon" practices of setting up "artificial social services-oriented CSOs" just to raise funds from international donors by state officials were noted in Kuts' study (2001), in which participants reported "local governments seeking grants from donors preferring to establish 'their own' CSOs in the relevant regions" (Kuts 2001, p. 22). Chapter 4 describes the proliferation of 'quasi' NGOs in GF-funded settings.

2.2 Post-1991 transitions: the HIV dimension

After the dissolution of the USSR, Ukraine plunged into a deep and painful socio-economic transition, characterised by economic crisis, inflation, loss of savings, and mass unemployment, exacerbated by the aftermath of Chernobyl. During a prolonged 1991-1999 recession, Ukraine lost 60 percent of its GDP and suffered five-digit inflation rates while one-third of the population plunged into poverty (UNAIDS ASAP, 2009).

Among the numerous aspects of post-Soviet transitions, several deserve a closer look in the context of the present research.

2.2.1 Trafficking in women. Migration.

In the 1990s, Ukraine became a 'supply country' and a major source of women for international sex markets (Hughes, 2000a). A brief historic outline of prostitution in Ukraine is provided in Appendix B.

During perestroika, despite the famous proclamation about "no sex in the USSR"[30] in the 1980ies, the phenomenon of *valyutnye* (hard currency) prostitutes began to spread, "glamorized in media by popular films such as *Interdevochka"* (Hughes 2000a, p. 15). *Interdevochki* (girls working on foreigners) were prolific in Intourist hotels in major cities and resorts in Crimea and Caucasus and met with little resistance from police.

With the rapid development of ex-Soviet states as "the hub and major supplier of women" (Stone, 1998), Ukraine became one of the largest origin countries of Slavic sex slaves after 1991, as well as a transit country for Asian and Indian sex workers to Western Europe (Hughes, 2002), earning "the biggest money for criminal groups in Eastern Europe" (Hughes 2000a, p. 21). The accounts of the numbers of the trafficked women in 1991-1998 varied between 500,000 as suggested by IOM (1998), and 400,000 women, suggested by Ukrainian Interior Ministry

[30] During perestroika, a popular 'Pozner-Donahue' TV Bridge (*telemost*) show connecting US and USSR audiences live, was created to show the policies of *glasnost*. During one such show, dedicated to the family life of Soviet women, one woman participant proudly proclaimed: 'There is no sex in the USSR!'

(Stone, 1998). Legally, prostitution in Ukraine was criminalised between 2001 and 2005 (Kerrigan et al, 2013), but later was de-criminalised, while liability for pimping, brothel operations and sex trafficking was made more severe. The Criminal Code of Ukraine does not define individual prostitution as a crime.

The existing discourse on prostitution/sex work in Ukraine – including in the context of HIV transmission - is ambiguous. It is not informed by the country's historic contexts; neither is it a product of the women's movement. Instead, it is externally-driven by donor-supported transnational NGOs. While different views on prostitution feature differently in international programmes in Ukraine, the role of the Ukrainian women and women's NGOs is mostly decorative. Organisations such as UNAIDS adopted the definition of sex work as receiving "money or goods in exchange for sexual services, either regularly or occasionally" (UNAIDS 2012a, p.3), while Coalition against Trafficking in Women, based in Banghok, European Women's Lobby, a Dutch-based NGO, and others, advocated legalisation of prostitution in FSU. USAID, a foreign policy arm of US government, on the contrary, was careful not to adopt the stance of 'promoting prostitution', and for many years, especially during the Presidency of George Bush Jr., USAID only supported ABC-centred HIV prevention. The role of aid in the discourse on sex work in FSU was noted by Hughes (2002) who argued that well-funded NGOs in Ukraine and Russia represented the funder's perspective, not the grassroots voices of people at home. Thereby, "the authentic voices in sending countries have been supplanted by the voice of the destination countries" (Hughes 2002, p.2). This issue is linked to a more global loss of role of post-communist women's NGOs, manifested by their failure in the 1990s to enter the global women's networks and incorporate the post-communist agenda on women into the key global framework documents including on trafficking and reproductive health [31] . Tensions in 'East-West sisterhood'

[31] Post-communist women's NGOs were unable to change the pre-formed global development agendas. During the 4thUN World Conference on Women in Beijing in 1995, 'A Voice from a Non-Region' statement was circulated among delegates, advocating for inclusion of women's issues of post-communist transition into the UN Framework Document, but did not succeed. The document is on file with the author. After the 4th Conference, attempts to consolidate Eastern European and FSU women's networks continued until the early 2000s but were not successful in winning donor support. Author's own experience with global women's movement informed the research.

relations[32] are well-documented in works of Einhorn and Yeo (1995), Havelkova (1997), Hrycak (2007), C.Kaplan (1997), Sperling (1999), N.Funk (2006), Wedel (2001), Pishchikova (2011), and others, while 'East' and 'South' tensions, also present at global forums, were not reflected in literature.

Due to unregulated character of the prostitution in Ukraine, it is organised by the criminal networks that may often operate in cooperation with law enforcement and government officials (Hughes, 2000a). Symbolically, the first NGO for sex workers established in Odessa in 1998 with support from OSI[33] - a famous *'Vyera, Nadyezhda, Lyubov'* (Faith, Hope and Love) - was headed by an acting police female officer working in crime prevention unit (UNAIDS 2007b).

Ukraine is home to a relative hierarchy of sex work which includes a top level of elite sex workers who are well paid and protected by security guards, personal doctors, and pimps. The middle category organizes in locations near hotels, bars and strip clubs as well as private residences. They often work with pimps or *mamochki* (madams) who take a portion of their salary in exchange for protection from police and clients. The lowest tier includes women working on the streets as well as those on highways, parking areas, train stations and bus stops; this group often includes drug and alcohol users as well as homeless women (TAMPEP, 2007). There is an ambiguity regarding the numbers of sex workers, and estimates fluctuate between 60,000 and 90,000 women. These numbers do not correlate with much higher numbers of migrants and victims of trafficking, suggested above.

Recently, inward sex tourism to Ukraine has become a growing trend. There were suggestions to regulate sex workers by police during EURO-2012 football championship (Schuster et al, 2010).

In the context of HIV transmission in Ukraine, the externality of the sex work discourse, added by a highly criminal and politically volatile environment, distorts understanding of the problem and narrows the scope of its application to the donor-supported programmes. This explains Ukraine's failure to develop a sensible policy on prostitution which is an important step in ensuring the rights and access of sex

[32] The term 'East-West sisterhood' was used ironically by Roth (2007) to describe the divides between East European and Western women activists and scholars over political and cultural issues of post-communist transition.
[33] Open Society Institute (OSI) - the fund by George Soros with headquarters in New York.

workers to health services. Epidemiologically, sex workers as a group are an important factor in Ukraine's HIV epidemic. Recent research suggests that Ukraine has the highest HIV prevalence among female sex workers in the EECA region (Kerrigan et al, 2013). Ukraine does not register HIV infection cases among CSWs (commercial sex workers) (UNGASS, 2012, p. 13). 'Blindness' of the official statistics – that puts HIV cases among CSWs together with other HIV sexual transmission cases - reflects the lack of a clear epidemiological vision of this group that impedes the development of an effective national strategy of HIV sexual prevention.

Migration

Throughout history, Ukrainian populations were highly mobile. Despite its fertile soils, Ukraine's populations often suffered from widespread poverty and resorted to earnings from non-agricultural activity, involving short and long-distance migration to factories and towns (Gatrell, n.d.). Following intensive labour migrations in 18th-19th centuries, populous Ukrainian diasporas developed in many parts of the world (Kichorowska-Kebalo, 2011).

The phenomenon of migration, although changing in scale and in direction, has remained a characteristic feature of Ukraine and the country is among the top ten in the world in its rate of outward migration, according to IOM. According to the data provided by Ukrainian Foreign Ministry, about 5 million Ukrainians work abroad, 65% of them are women (Kyzyma, n.d.). Ukraine is one of the main origin countries of exploited labour in Europe (UNHCR, 2012).As to the regions of origin, the Western Ukraine (Halychyna) bears a disproportionate share of all Ukrainian migrations:

Figure 2.3. Geographical distribution of Ukrainian labour migrants (IOM, 2011)

MAP 4. GEOGRAPHICAL DISTRIBUTION OF UKRAINIAN LABOUR MIGRANTS BY REGIONS OF ORIGIN[33]

There has been no empirical research on HIV prevalence among Ukrainian migrants. Research in other countries has shown that, once migrants arrive at their destination, HIV risk factors include being separated from regular partners, loneliness, and anonymity that influence their behaviour (ILO, 2005). Some engage in risky behaviour as a result of peer pressure, or the need to belong to a group or a community. Female migrants are especially vulnerable to abuse, violence, trafficking and inequality.

2.2.2 Weakening of the law enforcement. Drug-related policies and issues.

The collapse of Soviet law enforcement after the end of the USSR was obvious and predictable, given the heavy ideological component of its functioning. Dismantling of the monument to Felix Dzerzhinsky, the first head of NKVD[34], by angry crowds in Moscow during the August 1991 *putsch* (coup) became a media symbol of death of the empire. The Soviet collapse of the 1990s saw massive lay-offs in police, military, and security services just when the new states needed them most.

After the end of the USSR, Ukraine was left without the institutional capacity to address organized crime (Shelley, 1998). Most of the expertise and the institutions to deal with the problem remained in Russia, which inherited the centralized institutions of the Soviet state. Shelley suggested the central role of a criminal-political nexus - the alliance of the former party elite, members of the law

[34] NKVD - *Narodnyy Komissariat Vnutrennikh Del* - People's Commissariat for Internal Affairs.

enforcement and security apparatuses, and the organized criminals who together penetrate the licit and illicit sectors - was the most pernicious element of the crime phenomenon in Ukraine. The existence of such a nexus seriously distorts law enforcement.

In the context of post-communist transitions, it has become almost axiomatic to speak about the rise of HIV and growing drug use and prostitution by attributing their causes to economic crisis and joblessness. Rhodes et al (1999) spoke about social and economic 'risk environments' in which HIV spread rapidly. The growth of drug use was as much caused by the transition's social effects as by an unprecedented proliferation of production and distribution of drugs, which could not have happened without the weakening – and corruption – of law enforcement. A vivid description is given in Laurie Garrett's *Betrayal of Trust*:

> Stopping the Mafia, Gypsy gangs and other narcotraffickers in the region would be tough – perhaps impossible, psychiatrist Pavel Bem said. He insisted that regardless of what factors were driving the region's young adults toward drug addiction – the real crisis was how readily, and cheaply, the killer products were available.
>
> Almost without exception, narcotics and amphetamines could be purchased easily and openly, even in rural areas of Siberia or the frozen Arctic Circle. And sophisticated networks of gangsters and Gypsies, working with traditional drug traffickers from Nigeria, Afghanistan, Pakistan, and the Asian Golden Triangle, were moving across borders behind the once-Iron Curtain.
>
> 'These new economies are great opportunities for organized crime. And they are holding their prices way down at introductory levels', said Bem.
>
> Following universal rules of marketing, drug traffickers were creating clienteles in the region by selling everything from raw opium to heroin at rock-bottom prices, more than tenfold lower than equivalent drug sales in New York City.
>
> The cheapest high was *vint*, an extract of ephedrine allergy pills that were chemically oxidized to ephedrine, and powerful hallucinogen. In Moscow *vint* sold for three dollars…
>
> The primary selling point for *vint* was Lubyanka Square – across the street from the headquarters of the Russian police force formerly known as the KGB. (Garrett 2000, pp. 213-214)

After 1991 independence, Ukraine became a conduit for Southwest Asian heroin bound for European markets. Porous borders, understaffed and underfunded

counter-narcotics entities, and the rise of organized crime syndicates have enabled traffickers to utilize Ukraine as a viable transit point (Layne et al, 2002). Recent reports suggest an increasing share of Ukraine in global trafficking and call it "the drugs gateway to Europe" (The Ukrainian Week, 2013).

Drug use in Ukraine has been on the rise since 1991. In general, the drug policy of Ukraine was not consistent because it needed to comply with the country's international obligations and respond to internal crime problems. There is no liability for the use of drugs or psychotropic substances under the Ukrainian criminal legislation (Viyevskyy et al, 2011). Criminal liability exists for possession of drugs, psychotropic substances, or precursors not for sale purpose and in amounts exceeding the smallest allowable amount (Criminal Code of Ukraine, Article 309), or for the use of drugs in public or by a group of persons (Article 316), as described in Viyevskyy et al. (2011). High prices for heroin and cocaine have drawn many drug users to domestically cultivated poppy straw. Grown primarily in western and northern Ukraine, according to the Ministry of the Interior(Layne et al, 2002), weed and home-made opiates ("*shirka"*) were among the most popular drugs, due to the easy access to the raw materials and their profitability. Drug use when home-made opiates and medications are used together is quite widespread. A recent report suggests Ukraine becoming an important heroin consumption market in Eastern Europe (UNODC, 2011). The drug scene in Ukraine is changing and was not a subject of a detailed analysis in this study. More information can be found in Viyevskyy et al (2011), Layne et al (2002),Kaminskaya (2003), Nieburg and Carty (2012), WHO (2013).

Some authors tend to portray the growth of HIV within the domain of "political tensions between public health and law enforcement approaches to harm reduction and drug treatment" (Nieburg and Carty 2012, p.2), reporting punitive approach to drug use and violence towards drug users as the major barriers to improving access to HIV prevention in Ukraine and other FSU states (Rhodes et al. 2006; Rhodes et al. 2010; Rechel 2010; Strathdee 2010 et al.). It is sometimes argued that the reasons why drug users remain an 'easy and convenient target' were linked to existing practices of fulfilling crime statistics - the main criteria to evaluate police

performance in Ukraine that provides incentives for more arrest/imprisonment (Kucheruk, 2013). The role of external factors in the spread of HIV is also outlined. Neighbouring Russia spent billions of rubles on anti-drug and anti-drug trafficking policies, but in regard to HIV, was forced to acknowledge at a MDG Conference in 2011, that it "cannot resolve this, and the roots… of this problem are linked with the need to fight the drug threats coming across the border from Afghanistan."[35] Prohibitionist Russian drug policies were believed to influence Ukraine. Some research suggested that Russian science, which opposed harm reduction including OST, continued to influence government officials and healthcare providers in Ukraine (Spicer et al, 2011). In April 2012, the Head of the Parliamentary Commission on Health, influential Tetyana Bakhteeva indicated during a meeting in Kyiv with Lord Fowler, Chair of the UK House of Lords' Select Committee on HIV and AIDS, that despite the importance of syringe exchanges and substitution treatment in tackling HIV, "the Ukrainian government would not be able to take over the responsibility for harm reduction programs or finance them" (International HIV/AIDS Alliance, 2012a).

2.3 The health care in Ukraine before and after 1991. HIV/AIDS health care.

2.3.1 Semashko system and its collapse. Post-1991 health reforms.

The Soviet Union was a welfare state with free universal health care, free education, and most other services provided by the state. The Soviet health system delivered comprehensive medical services, including in the most remote areas. Known as 'Semashko system'[36], fully public and highly centralized health care was one of the strongest pillars of the Soviet system. An outline of health system in the USSR is given in Appendix C.

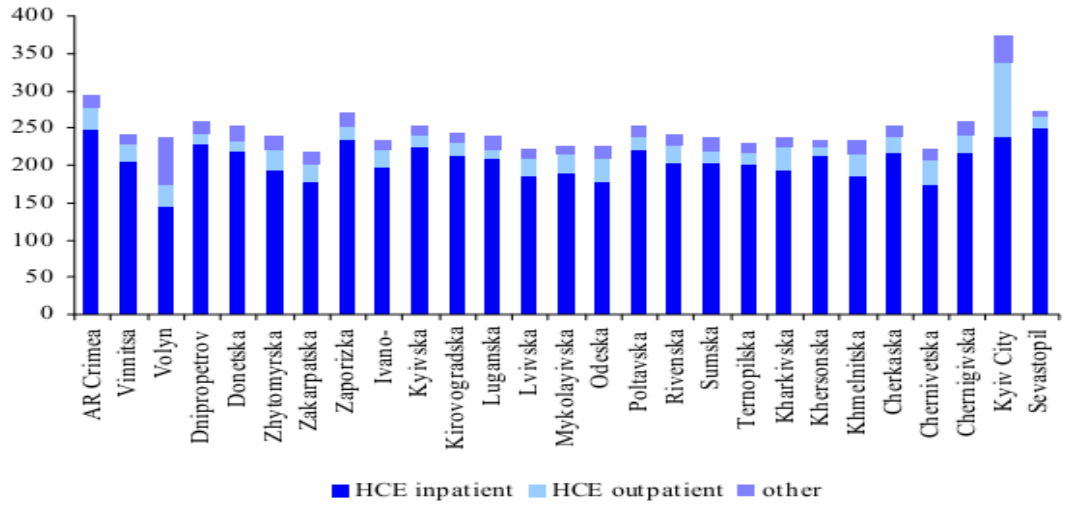
The break-up of the Soviet Union led to "the most astounding collapse in public health ever witnessed in peacetime in the industrialised world. For the Euro-Slavic world it would be the most radical reversal, in the absence of war, since the Black Death of the fourteenth century" and it became "*one of the most catastrophic consequences of the dissolution of the USSR"* (Garrett 2000, p.113). [emphasis

[35] Speech of the Foreign Minister of Russia (Lavrov, 2011).
[36] Nikolai Semashko (1874-1949), People's Commissar of Health and later a USSR Academician, Lenin's advisor on health, is considered a 'father' of Soviet health care system.

added] Post-Soviet independent states were torn between preserving at least some features of the previous health care system and reforming it.

After 1991, Ukraine retained entitlement to universal health care. In mid-1990s, it attempted devolution from a centralized model of decision-making and financing of health care to its extreme decentralization and delegation of authority to local administrations. The 1997 law "On Local Self-Government in Ukraine" devolved significant budgetary authority to oblast and district councils (Gotsadze et al, 2010), while leaving health facilities administratively subordinate to MOH. As a result, healthcare responsibilities were fragmented among central government and regional administrations, which has constrained implementation of health policy (Lekhan et al, 2010) and made most health care entitlements, guaranteed by the Constitution of Ukraine, essentially rhetoric. The process of health care decentralization led to increasing inequalities between 'wealthy' and 'poor' oblasts of Ukraine. In regions lacking sustainable income, the health system became a heavy burden on local budgets. This was meant to change in 2001, when financing was re-centralized under MOH, separating service provision from local authorities and ensuring that operating budgets were not influenced by local politics (Gotsadze et al, 2010). The mechanisms introduced allowed some smoothing of territorial differences, but the scale of inequalities remained significant (Lekhan et al, 2010). The level of health care expenditures (HCE) is uneven between Ukraine's regions:

Figure 2.4. Health care per capita expenditures in 2005, in Ukrainian hryvnas (UAH) (Betliy O et al, 2007)

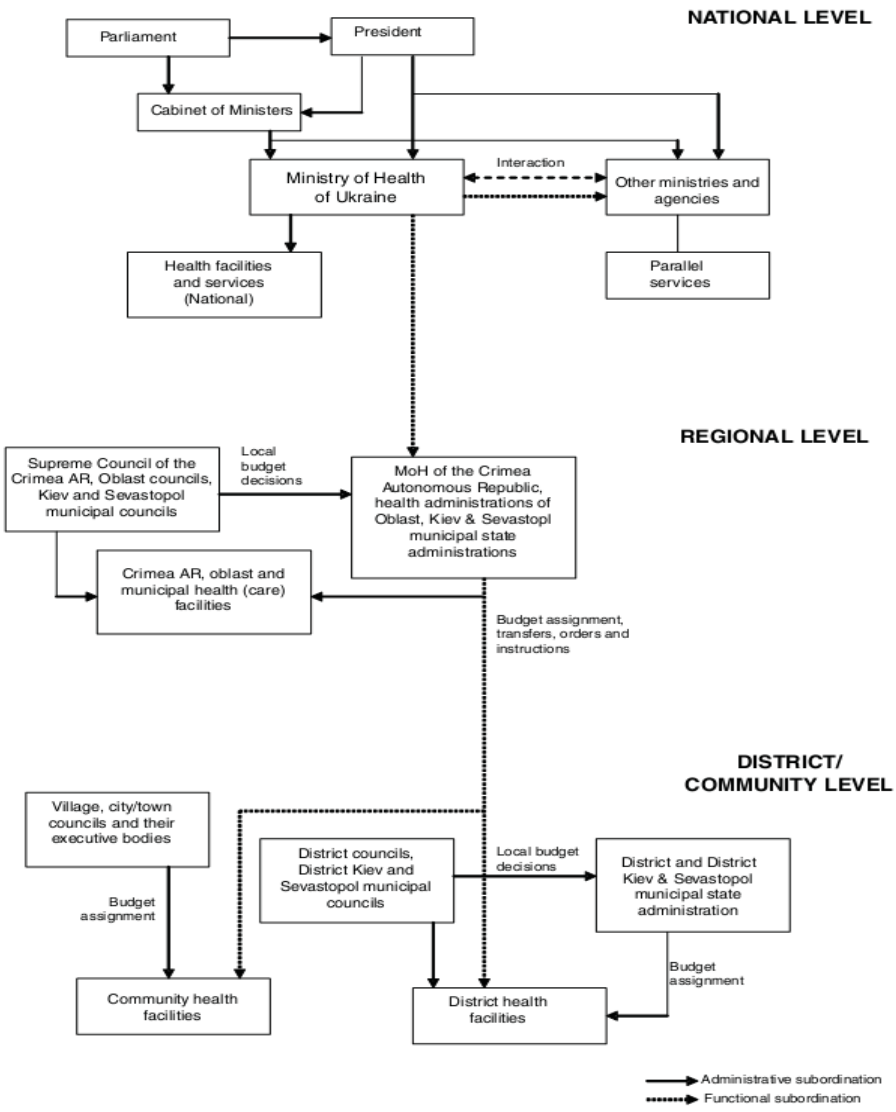


High-income regions, such as the city of Kyiv, the Crimea Autonomous Republic, and Zaporizhia, Dnipropetrovsk and Donetsk oblasts, are able to provide their residents with better-financed health care. The graph also shows that the large part of HCE is spent on inpatient care.

Differences in regional health service capacity have significant implications for the HIV care delivery.

At present, MOH has overall responsibility for the public health care system (see Figure 2.5 below). Its official role is confined mainly to setting norms and standards of health care and developing policy as well as procuring drugs (Lekhan et al, 2004). At the oblast level, the oblast health administration – *oblzdrav*– is responsible for regional health care facilities. At the district level, town and village administrations have authority over district health facilities.

Figure 2.5. Structural organisation of health care in Ukraine (Lekhan et al, 2004)



There is a discrepancy over the role of MOH in policy making. While the 1992 Law of Ukraine on 'Principles of Legislation on Health Care in Ukraine' holds the Verkhovna Rada (Parliament) responsible for developing the national policy, setting standards, allocating budgets, and creating national health care programs (Betliy et al, 2007), in practice these issues are determined by MOH.

In 2011, Ukraine launched another attempt at healthcare reform, to introduce new approaches in the healthcare sector, enforce quality standards, and change the healthcare funding system by introducing the health services request (MOH, 2012).

Overall, in most post-communist countries, post-1991 health reform decisions were made on the basis of politics rather than evidence. The rush towards reforming

health systems was often motivated by a political desire to distance from the communist ideology that Semashko system so strongly embodied. Agencies such as World Bank have played an important part in post-Soviet health care reforms. Foreign experts who had prominent roles in the early days often had little insight into local situations (Rechel and McKee, 2009). As was the case in other countries, they often concentrated on 'policy transfer' (Hudson and Lowe, 2009) rather than on building domestic capacity.

Ukraine's current health system may be characterized as a 'hybrid' of Semashko because it "preserved its fundamental features" (Lekhan et al. 2010), with many elements of old health care still present. One such element is a system of the specialized AIDS centres – a vertically structured health system whose foundations were laid in late Soviet Semashko health care.

2.3.2 Early days of HIV epidemic in the USSR. Soviet response to AIDS

Due to the closed nature of the Soviet system, the region experienced a slow start of HIV/AIDS. The first cases of HIV in the USSR were associated with Soviet citizens returning from abroad, as well as unprotected sex with foreigners, primarily male students from African countries (Vinokur et al, 2001). The majority of sero-positive females in Leningrad (now St. Petersburg) during the 1980s had multiple sexual contacts with foreigners (Kozlov et al, 1993).

Although the first official information about AIDS[37] was released in 1987, there were earlier direct and indirect signs that the epidemic had entered the USSR. Among the indirect signs was the *Prikaz* (Order) of the MOH of the USSR of 10.06.1985 (Ministry of Health of the USSR, 1985). While the Order stated that cases of AIDS were recorded in the USA and no AIDS cases had been discovered in the USSR (Khozhylo, 2008), nevertheless, it decreed the organization of mass screenings and opening of specialized diagnostic labs to test for AIDS. Other official documents emerged soon afterwards – among them the amended Order of the MOH of 09.07.87 that introduced a requirement of mandatory AIDS testing of all foreign

[37] Initially, in Soviet documents, the disease was called *sindrom priobretennogo immunodeficita – SPID* – meaning AIDS syndrome.

students already in the USSR, and an entry ban to the Soviet educational establishments for AIDS-diagnosed foreign nationals (Ministry of Health of the USSR, 1987). Those documents indicated a "double standard" in AIDS statistics (Khozhylo 2008, p. 49), and suggested that there were already known cases of AIDS in the USSR before 1987.

The direct evidence came in a 'bombshell speech' in Paris in 1986 by Dr. Victor Zhdanov, head of the Ivanovsky Institute of Virology of the USSR Academy of Medical Sciences, at the Second International AIDS Conference (Garrett, 2000, p. 201). Zhdanov, a top Soviet AIDS expert at the time, a member of the WHO Executive Board (Kaplan, 1999), openly defied the Soviet authorities by revealing that claims that there was no AIDS in the USSR were untrue, and that small outbreaks of the virus were appearing in parts of the USSR, including Moscow where the virus had been discovered in 12 out of 10,000 people screened by his unit (Nahaylo, 1986). Upon Zhdanov's return from Paris, a 'witch hunt' campaign was unleashed against him and he was denounced as a 'CIA spy', while several unsigned articles appeared in Soviet scientific journals questioning his credibility as a scholar. Allegations were to be investigated by a commission headed by Valentin Pokrovsky, President of the Academy of Medical Sciences of the USSR (Garrett, 2000). 75-year old Zhdanov, having suffered a stroke, was summoned to the commission where he fell victim of vicious personal attacks and died shortly afterwards[38].

Initially, Soviet health authorities intended to place HIV and AIDS into the sexually transmitted infection (STI) network of the health care system, which seemed rational given the predominantly sexual mode of transmission of the first HIV cases in the USSR. But eventually, a separate system of AIDS clinics and labs was established.

The Law on AIDS passed in August 1987 focused primarily on punitive measures (Belikov, 1987). The law made HIV testing obligatory and criminalized transfer of the infection (Medvedev, 1990). Among other measures, it required:

[38] Meanwhile, Pokrovsky's son Vadim was appointed the head of a new HIV/AIDS Laboratory and Clinical Centre in Moscow (Garrett, 2000). Now called the Russian Federal AIDS Centre, it is still headed by Vadim Pokrovsky at the time of writing.

- foreigners living in the USSR for more than three months to undergo an HIV test,

- Soviet citizens returning home after one month or longer abroad to be tested for HIV,

- physicians to test anyone whom they suspected might be infected, and

- up to eight years prison terms to those who knowingly infected others.

The 1987 legislation also called for expulsion of non-Soviet citizens who refused to be tested. Williams (1995), Powell (2000), Medvedev (1990) and others criticized Soviet anti-HIV legislation for creating a climate of fear between possibly infected people and medical authorities. Patients feared being found HIV positive because of the discrimination and possible imprisonment for transferring the infection, and medical personnel were afraid of being accused of accidentally infecting patients. Feshbach described cooperation between those at risk and the medical authorities as "impossible" (Feshbach 2007, p.29).

In 1987-88, a computer system for the registration and analysis of all HIV testing activities was established, and in the following year a centralized system of AIDS Centers and diagnostic laboratories was created. At the beginning of 1989, about 17 million people had already been tested. By late 1991, just before it disintegrated, the Soviet Union had 1,015 HIV diagnostic laboratories, 110 prevention centers (of which 80 were in Russia), and 200 special consulting centers for anonymous blood testing (Williams, 1995).

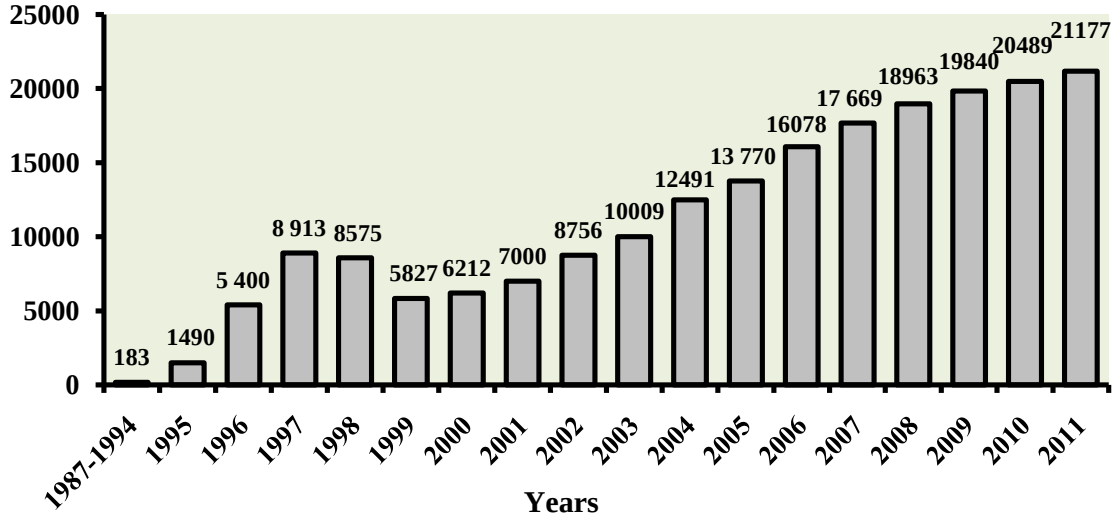
As a result of these institutional choices, however discriminatory, the Soviet health system was able to prevent most of the initial outbreaks of HIV/AIDS. The early response to AIDS resulted in a network of AIDS centers that were segregated from the general health care system. The collapse of the health care system, and abandonment of many typical Soviet anti-epidemical measures, intensified the multiple dilemmas involved in HIV/AIDS control.

2.3.3 HIV/AIDS epidemic in Ukraine

Until 1994, the number of HIV-infected people in Ukraine was low. Between 1987 and 1994, over 39 million tests were carried out, and only 398 people were identified as HIV positive, of whom 215 were foreigners (Barnett and Whiteside

1999). The number of reported HIV infections increased extremely rapidly in the second half of the 1990s (Harmer 2000).

Figure 2.6 Newly registered HIV cases among citizens of Ukraine in 1987-2011 (Ukr. Centre for for Socially Dangerous Disease Control).



Increasing HIV infection rates were masked by a decrease in testing after 1998 when Ukraine adopted the Law "On Prevention of AIDS and Social Protection of People", which made HIV testing voluntary (WHO 2005). Some sources note that, while conforming to international standards aiming to protect the human rights of PLWHA, the law "made the collation of data obtained prior to and after 1998 complicated" (British Council 2001, p.17).

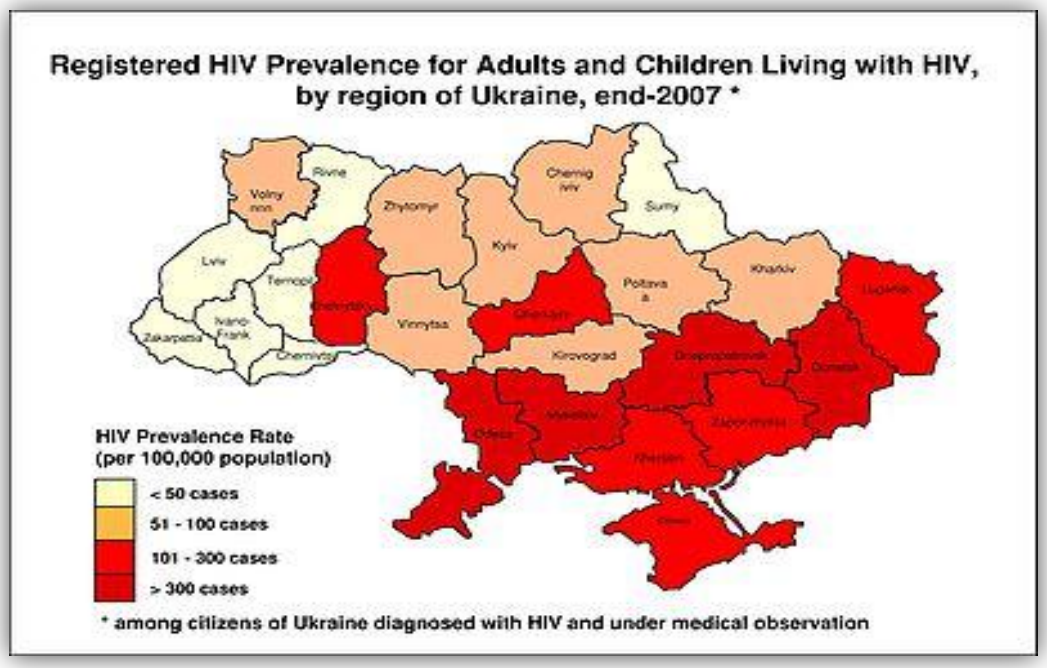
Research suggested the growth of the HIV epidemic was in line with Ukraine's regional divides:"The increase was initially observed and was particularly striking in the regions along the Black Sea" (Hamers 2000, p. S5). DeBell and Carter (2005) spoke about 'Ukraine's River Dnieper corridor' comprising the parts of Ukraine with the five highest rates of intravenous drug users Dnipropetrovsk, Odesa, Kyiv, Mikolaiv, and Zaporizhia, all lying along the Dnieper:

Figure 2.7 Ukraine's 'River Dnieper corridor' with a high coincidence of drug use and HIV rates (reproduced from DeBell and Carter, 2005, p.217)

The World Bank also singled out Donetsk, Dnipropetrovsk, Odessa, Mykolaiyv and Crimea as the most HIV-affected regions in Ukraine (Bank, 2009). Gukalova (2006) suggested that HIV rates correlated with the income level of population and were higher in *oblasts* with higher wage level, linking the latter to the ability of people to be able to afford a more 'free life style' – i.e. to use drugs, purchase sex etc., she also suggested an increased susceptibility to HIV in 'mono-towns'[39]. In 2008, HIV prevalence in *oblasts* looked like following:

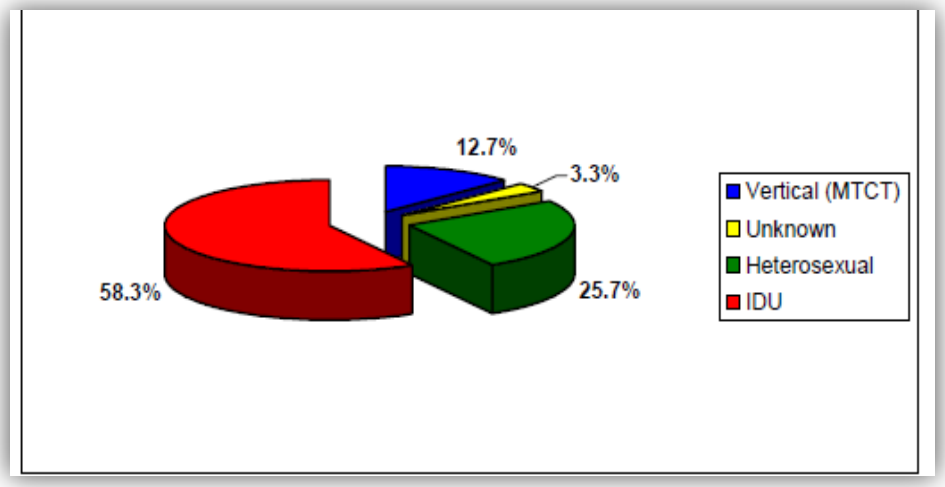
[39] 'Monotowns' or 'mono-industrial towns' in the Soviet Union were urban settlements with an economic base dominated by a single industry (Karam, 2011). The closure of an industry would mean the whole town population would become unemployed.

Figure 2.8 HIV prevalence in the regions of Ukraine in 2008 (Ukr.AIDS Centre)



In 1999-2002, the main mode of HIV transmission was intravenous drug use (IDU):

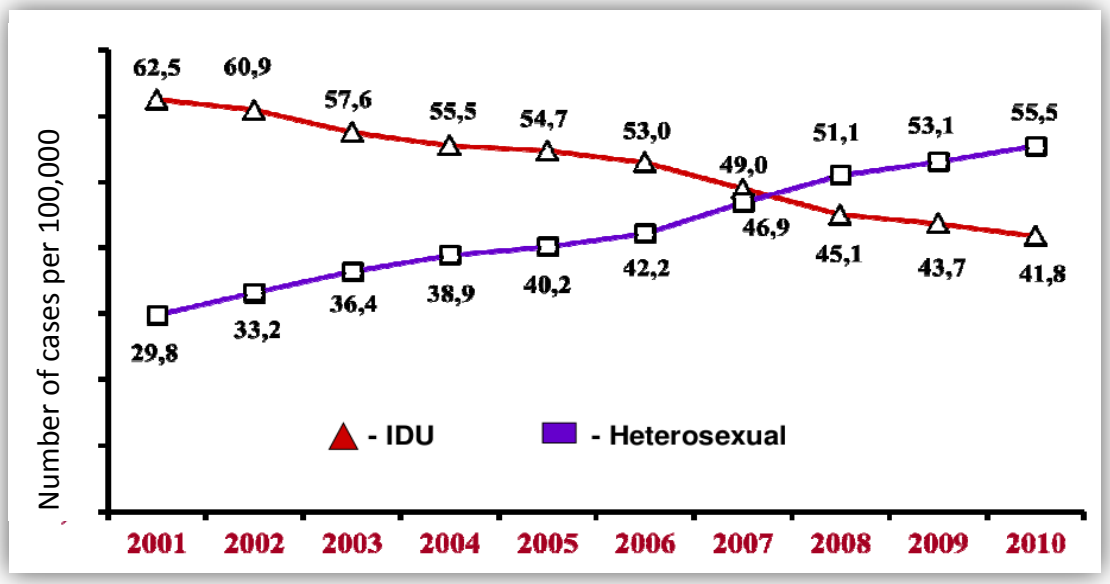
Figure 2.9 HIV/AIDS in Ukraine, by route of transmission: 1999 to 2002



Source: Ukrainian AIDS Centre.

Around 2007-2008, heterosexual transmission became the main mode of HIV transmission:

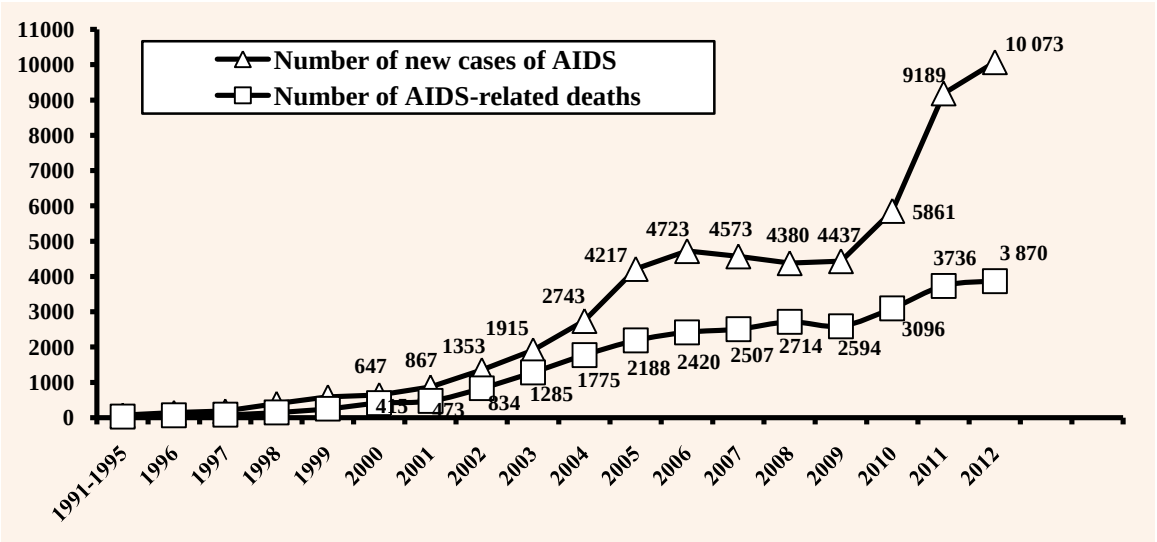
Figure 2.10 The routes of HIV transmission in Ukraine (Perehinets, 2012)



As of 11.02.2014, there were 247,101 registered cases of HIV-infection, over 66,607 registered AIDS cases, and 32,283 AIDS deaths (Ukr.Centre for Disease Control).

Suggestions made by Matic (2006) about 'a maturing HIV epidemic' in Eastern Europe, correlate with an alarming increase in AIDS morbidity and mortality:

Figure 2.11 New AIDS cases and AIDS-related deaths per year among citizens of Ukraine in 1991-2012,Ukr.Centre for Disease Control



Official data on HIV was frequently criticised for inconsistency and confusion over HIV screening results (Feshbach and Galvin, 2005), and donor organisations use estimated numbers. Estimates obtained through donor-funded research have also displayed a wide variability (see Appendix D).

2.3.4 National governance mechanisms on HIV/AIDS

Due to the nature of vertical decision-making in Ukraine, at both the national and local levels, coordination and collaboration with international donors are often left to individual personalities and interests of those involved (Judice et al. 2011). Persisting political instability in Ukraine's government has led to frequent turnaround of ministers of health. Continuous policy upheavals that accompany frequent personnel changes has led the MOH to be described as the "'rain forest' of bureaucracy"(World Bank 2009, p. 16).

Ukraine's government response to HIV/AIDS began in 1991 when Parliament adopted the Law on AIDS Control and Social Protection. Evolution of Ukraine's national governance on HIV/AIDS may be divided into two periods:

(a) 1992 to 2000 - a 'President-centred' period, when national governance institutions were built up under direct control of the President of Ukraine. This period is characterised by a stronger mandate of AIDS state institutions, including participation in budgeting and state planning.

(b) After 2000 until now - 'MOH/donor-centred.' AIDS governance mechanisms formed to comply with Ukraine's international obligations. Their mandate became weaker and unclear, and authority was divided between the MOH and multi-sectoral coordinating bodies that included international stakeholders.

'President-centred' period

In 1992, President Leonid Kravchuk established the National Committee for the Prevention of Drug Abuse and HIV Infection that included top medical experts, executive officials from ministries of interior, health care, education and others. The Committee reported directly to the President, had control over AIDS

funding, and authority to institute anti-AIDS policy nationally and in oblasts, as well as to represent Ukraine abroad. From 1993 to 1998, the Committee was headed by Valery Ivasyuk. In 1996, the Committee established oblast AIDS committees (National AIDS Committee, 1996) as mechanisms of regional governance. The first four AIDS centres were also established in Zaporizhia, Donetsk, Dnipropetrovsk and Kyiv (Khozhylo, 2008). In 1997, scandal erupted in Ukraine when incidents of HIV transmission via donor blood raised concerns over the safety of its blood transfusion systems (Gorchinskaya, 1997). Ivasyuk accused a group of top officials for lobbying for a ban on importing HIV test systems to Ukraine (Kyiv Post, 2001), and promoting domestically-made test systems that, in his opinion, were responsible for producing many false results. Despite his protests, the decree signed by Ukraine's Prime Minister Pustovoitenko on January 19, 1998 (The Cabinet of Ministers of Ukraine, 1998) gave a monopoly for procuring test systems to one company - *Diaprof-Med* (The Kyiv Post, 1998). In January 1998, President Kuchma, allegedly influenced by vested interest groups, fired Ivasyuk from his post and in May 1998 disbanded the National AIDS Committee.

A year after the disbandment of the Committee, the National AIDS Coordination Council was formed in 1999 under Vice Prime Minister Volodymyr Seminozhenko, with support from UNAIDS and other donors (World Bank, 2009). It was replaced by the National Commission on AIDS in November 2000, following Ukraine's commitment to the UN MDGs (Lekhan et al, 2004). Some functions of the disbanded National AIDS Committee transited to the Ukrainian AIDS Centre. However, the strong governance mandate was lost.

In 2000, Ivasyuk took part in the medical examination related to the murder of journalist Georgy Gongadze. After series of threats and accusations of embezzlement of state funds (Ukr.Pravda, 2001), he fled to Britain and applied for political asylum (Penketh, 2001).

'MOH-centred' governance

From the beginning of the 2000s, national AIDS governance centred around the MOH. The mandate was shared between the MOH and the National AIDS

Council (NAC), with many governance functions duplicated (Khozhylo, 2008). Inside the MOH, the Department of Socially Dangerous Diseases was established in 1999.Its role and mandate were believed to be weak and ability to make meaningful decisions independently in question (World Bank, 2009). The role of NAC, despite being headed by the Vice Prime Minister, was mainly recommendatory. In light of frequent changes in this position, the Vice Prime Minister had limited direct involvement in oversight of the Government's response to AIDS. During the GF grants, NAC evolved into a Country Coordinating Mechanism (CCM).

The 'Orange Revolution' in 2004 was accompanied "by concomitant improvements in HIV/AIDS programmes"(Matic 2006, p. 13). In 2006, President Yushchenko signed a decree creating a new National HIV/AIDS Committee and put the repatriated Ivasyuk in charge, who was also appointed Deputy Minister of Health. The Committee struggled for a mandate; it was subordinated to MOH with inadequate authority to coordinate across different government agencies (UNAIDS, 2009). It also was not funded. Yushchenko accused the government, then headed by rival Victor Yanukovych, of sabotaging his decree and not putting funding for the Committee into the state budget. Yushchenko even threatened not to sign the 2008 Budget if funding for the AIDS Committee was not included (UNIAN, 2007), however, these threats never materialised. With another change of government, Ivasyuk lost his post.

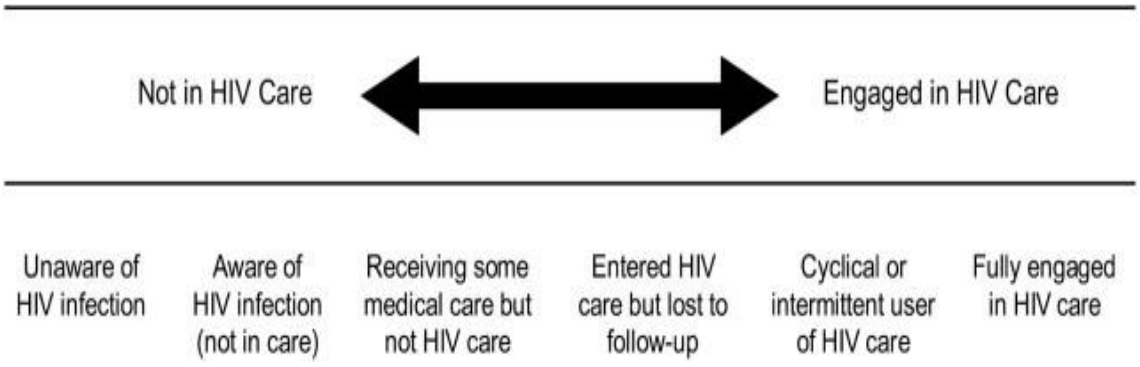
Under a range of changing appointed heads (V.Petrenko, S.Cherenko, O.Fedko), the Committee slowly expanded its role and responsibilities. As Ministers of Health changed frequently, the Committee held *de facto* delegated responsibility for the national AIDS response. In 2010 it transformed into the State Service on Combating HIV-infection/AIDS and Other Socially Hazardous Diseases. Despite being called"a high level agency with a wide decision-making authority" (MOH, 2012), State Service continues to be subordinated to MOH and operates within the framework of the National AIDS/TB Council. It also performs functions of the National Council Secretariat in relations with the GF (MOH 2012, p. 14). A detailed discussion of country coordination during the GF R1-R6 grants and research findings are presented in Chapter 6.

2.3.5 HIV/AIDS health care entitlements. HIV prevention. HIV testing.

The Law of Ukraine on AIDS commits the Government of Ukraine to universal access to HIV treatment and care, with free treatment for all patients with HIV/AIDS. To enter ART and other treatment, an infected person needs corresponding medical indices and be willing to register (UNDP 2008).

For individuals with HIV-infection to fully benefit from potent combination antiretroviral therapy, they need to know that they are HIV infected, be engaged in regular HIV care, and receive and adhere to effective ART (Gardner et al. 2011). The 2012 WHO strategic HIV testing and counselling programme framework specially emphasizes the importance of ensuring linkage between HIV testing and counselling programmes and prevention, treatment, care and support services (WHO 2012). The HIV care continuum - also known as the HIV treatment cascade - is a model describing the delivery of services to PLWHA across the entire continuum of care:

Figure 2.12 A model of HIV treatment cascade (Gardner et al.2011)



The HIV care continuum schemes, as well as WHO ART guidelines, have been evolving over years globally, and below is a brief overview of their evolution in Ukraine.

Entitlement to ART, including among other indices, the CD4 cell count, has varied. At the beginning of the GF programmes in 2003, the ART start threshold required a CD4 cell count of 200 cells/mm^3 (Protocols for treatment of HIV-infection, MOH of Ukraine) that was linked to low availability and high costs of ART. In August 2004, ART provision was launched in six oblasts under the Round 1 GF program. By 2008, it was gradually scaled up to all oblasts. Ukraine's UNGASS

report indicated that death on ART (related to late initiation of ART) was among the main reasons to discontinue ART during the first 12 months after initiation of treatment in the 2004-2007 cohorts (MOH, 2012). In 2007, according to the Base Standard for Implementation (Extension) of ART for PLWHA (MOH 2007), the CD4 cell count threshold for the start of ART was lowered to ≥350 cells/mm^3, leading to increased numbers of eligible patients. The following year 2008, after a vocal lobbying campaign by GF implementers, most of the patients on ART, funded through GF grant, were passed into state care. For the government, ART costs were the lion's share of the state AIDS budget. The rate of funding for the national AIDS programme and capacity of AIDS centres lag behind the growing number of patients in need of treatment. ART coverage of HIV-infected people and their follow up were insufficient and the coverage rate fell in 2011 (2010 – 84%, 2011 – 82.3%)(MOH, 2012). As of 01.01.2012, 83% of patients were getting treatment with support from Ukraine's state budget and 17% with support from the GF (MOH, 2012).

HIV prevention in Ukraine: an overview

National research in Ukraine (Khozhylo, 2008) as well as international sources (Merson, 2007) view HIV prevention as a holistic process that includes:

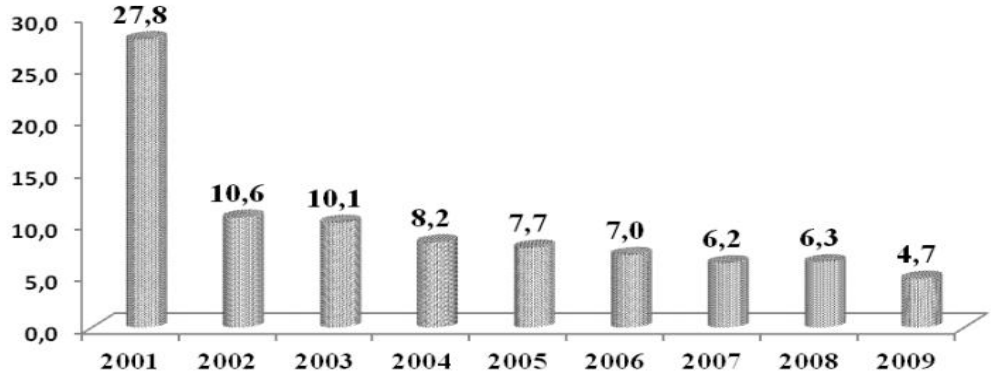
- primary/negative prevention – preventing individuals presumed as HIV negative to contract HIV-infection by various measures;
- secondary/or positive prevention (PP) – prevention of HIV transmission from HIV-positive individuals to uninfected individuals; and,
- tertiary prevention – also including care – that involves a higher adherence by HIV-positive individuals to ART and other treatments, as well as social care such as providing food, clothing, and access to free services outside of the health care system.

A holistic view of HIV prevention, as of any other disease prevention, is deeply rooted in the legacies of the old Semashko preventive approach to infection control. Unlike the USSR, Ukraine has always struggled with funding the various prevention approaches that have evolved as the government's views on HIV prevention changed at different stages of the HIV epidemic.

A MOH report described HIV prevention as the major priority in the state policy, and all the key line ministries are involved in the implementation of prevention programs (MOH, 2012). **Primary prevention**, under the new policy is based on articulated principles of a healthy lifestyle and family values. A national healthy lifestyle logo (see the picture), principles of the "Constitution of a Healthy Human Being" (Ministry of Education, n.d.), and special awareness-raising programs were developed. The issue of HIV prevention has been integrated into the work of the Ministry of Education and Science to address the issue of quality of HIV prevention classes at educational institutions and the level of teachers' training and qualifications. A special Order was issued by the Ministry to set standards in these areas. However, there was no budgetary funding for prevention programmes in education. (MOH, 2012).

Prevention of 'mother-to-child' transmission (PMTCT). According to MOH, implementation of the National Programme for PMTCT remains the only intervention in Ukraine to reach most of the target population with quality services (MOH, 2012). The programme is fully funded by the state and is believed to have been successful in lowering the MTCT rates (UNDP, 2008):

Figure 2.13 HIV transmission from mother to child in Ukraine, in % (MOH, 2012)



Focused (positive) prevention (PP) - among high-risk populations is carried out under the GF project (MOH, 2012). The coverage of IDUs' sexual partners with

prevention programs is low. There were changes in the operation of social services due to government restructuring reform. The scope and magnitude of prevention programs among MSM and those implemented in prisons are insufficient. There is no appropriate strategy for screening blood donation or for infection control (MOH, 2012). Most PP interventions in the populations most at risk of HIV were supported by donor organizations and implemented by civil society and some faith-based organizations, largely without control or support from the government (MOH, 2012).

In its prevention policy, Ukraine accepted international recommendations that a correct understanding of HIV epidemic should influence the choice and focus of HIV prevention and populations that it targeted. This UNAIDS approach, known as "Know Your Epidemic, Know Your Response" (UNAIDS, n.d.), "a rallying cry for an intensified focus on HIV prevention" as noted by Wilson and Halperin (2008), had produced mixed outcomes globally:

> .. [F]or too long, the global HIV-prevention community has pursued generalised responses in concentrated epidemics, concentrated approaches in generalised epidemics, or hedged their bets and done a bit of everything" (Wilson and Halperin 2008, p. 423).

In Ukraine, despite the change in the main mode of transmission in 2007-2008, the view on its HIV epidemic as *concentrated* among groups of high-risk, with IDU as a dominant mode of HIV transmission, was continuously promoted by international donors. During the GF R1-R6 programmes, there was no agreed perception of Ukraine's HIV epidemic[40]. Research participants reported that the PRs adoption of external view on Ukraine's epidemic as concentrated among IDUs resulted in the lack of sensitivity of GF-funded prevention interventions to adjust to the changing nature of the epidemic. More details are provided in Chapter 5.

HIV testing

In Ukraine, testing for antibodies to HIV is considered an important part of prevention. Testing practices in Ukraine have undergone four stages (Appendix E).

[40] A number of Ukraine's stakeholders reject the notion of its HIV epidemic as concentrated. Some publications suggested that in several parts of Ukraine, epidemic was already generalizing (see for example UNDP (2000), DeBell and Carter (2005)). Later, the term 'mixed epidemic' has been used by UNAIDS representatives and researchers (Alistar et al. 2011) in relation to Ukraine.

Ukraine implements the 'combined voluntary counseling and testing (VCT)[41] model' that is administered in state-funded hospitals, STD clinics, narcological and TB dispensaries, family planning centres and antenatal clinics (Varban et al, 2012). Ukraine has an extensive, tiered HIV laboratory system. Virologic and immunologic testing is done at an increasing number of the 27 regional AIDS center laboratories as well as at a central HIV reference laboratory. There are also 761 state-funded 'Dovira' ('Trust') centres in all *oblasts* (Perehinets, 2012) that conduct express testing and counseling and are approximated to residential areas. A considerable number of private laboratories also conduct HIV tests. Due to the stigma associated with HIV, many people choose to do HIV screening at the private labs, however, no data were available on how many private labs conducted how many HIV tests, and no reporting model was developed for them (British Council 2001). Express (rapid) tests are also administered by HIV-service NGOs (Varban et al, 2012).

The aim of HIV testing is to determine eligibility of PLWHA to receive ART and other entitlements stipulated by law. To receive these entitlements, a person's HIV status needs to be confirmed through a *pidtverdzhuvalny* (confirmatory) testing for antibodies to HIV ½, and antigen p24 HIV-1 (The Ministry of Health of Ukraine, 2012) – for which a venous blood is taken for an immune-fluorescence assay (IFA) test conducted at the AIDS center laboratory, followed by a waiting period of between two weeks and one month. Only after a confirmatory test proves positive, it serves as an entitlement to enter the HIV continuum of care. The patient is then put on a dispensary list (*dispansernyi oblik*), which requires registration and submission of individual passport data to AIDS centre.

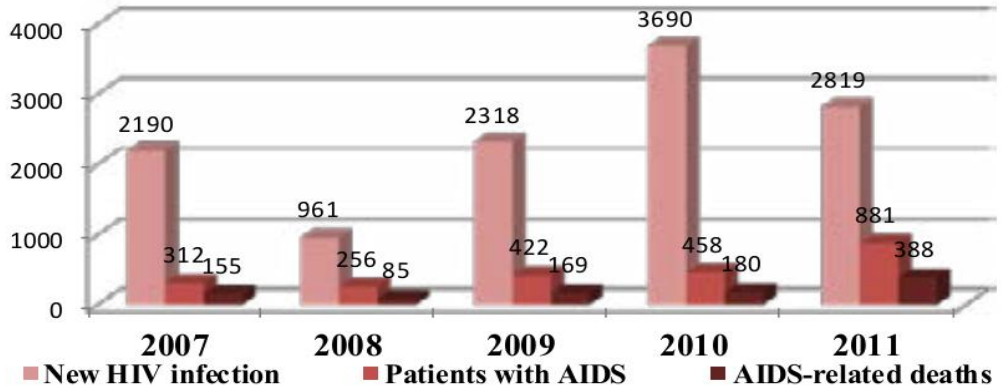
Two populations are universally tested in Ukraine – blood donors and pregnant women who attend ante-natal clinics (ANC), with procurement of their HIV test kits provided by the state budget. UNAIDS describes coverage by testing of other populations as "low and inconsistent" (UNAIDS 2009, p. 30). Because test kits for testing general population are procured by the *oblast* budgets, in oblasts with limited financial capacity[42], the number of registered HIV cases may significantly underestimate prevalence rates (MOH, 2012).

[41] In other sources, the system is referred to as HIV Testing and Counselling (HTC) (Perehinets 2012).
[42] See the differences in oblasts health budgets presented in Figure 2.1 on p.77.

Prison system

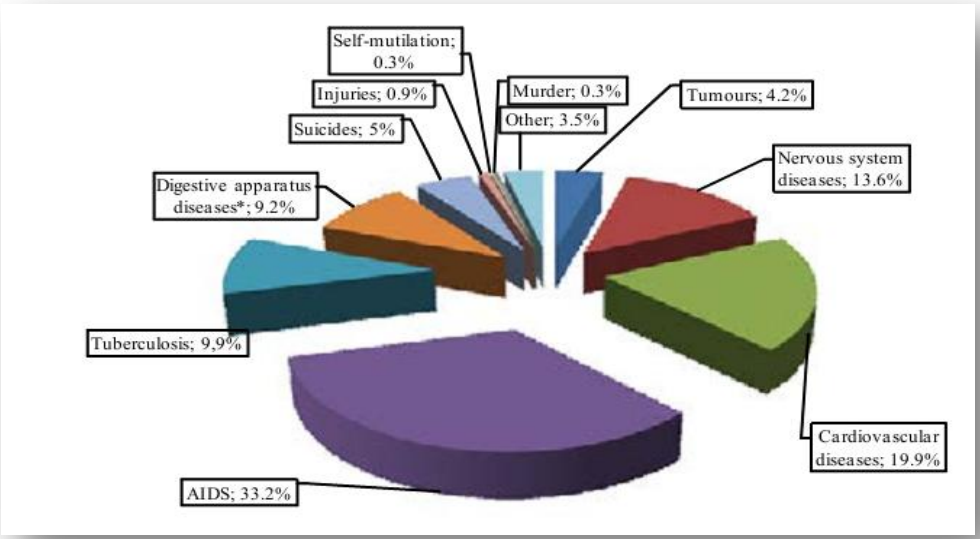
Ukraine has a significant number of prisoners – about 350 per 100,000 people. The total number of inmates in Ukraine was 145,189 as of February 1, 2013 (Departament, 2013). In 2005, between 15 and 30 per cent of prisoners in various prisons across Ukraine tested HIV positive (AIDSLEX, 2006). The share of HIV positive individuals and AIDS-related deaths among the prisoners was rising:

Figure 2.14 Numbers of officially registered HIV positive individuals, patients with AIDS, and AIDS-related deaths among prison population in Ukraine (UNODC 2012, p. 24)



After 2010, AIDS has become the leading cause of death among prisoners and detainees (see Figure 2.15):

Figure 2.15 Causes of deaths of individuals in places of confinement



(UNODC, 2012, p. 27)

The prison system and its statistics are sometimes difficult to verify as some may be 'classified' as in Soviet times, besides, it's a different jurisdiction within the Ministry of Justice, and has a separate health system. The infection rates for HIV and TB in prison system as well as available services need to be researched independently.

Drug clinics (*narcological dispensaries*)

The treatment of people with drug problems in Ukraine is carried out at a tertiary level by a vertical system of narcological dispensaries. MOH approves the list containing types of drug treatment facilities and departments (Ministry of Health of Ukraine, 2002). The financing of these institutions/departments is provided by the regional budgets and partly at the expense of the out-of-pocket payments by patients. Medical procedures associated with treatment of patients with drug dependence are to be carried out by a state narcologist (Vievsky, 2011). In addition, treatment of people with drug abuse problems may be carried out by private health care institutions and private narcologists, with the clients paying for their treatment.

The narcological service is often seen as an atavism of Soviet health care, where it was a sub-discipline of psychiatry, and the state confined drug and alcohol addicts to locked facilities for blood purification procedures, aversion therapies and the use of labour as therapy (Latypov, 2011). Its legacy of registration requirements of patients with drug problems and periodic visits to the narcological center (Celentano and Beyrer, 2008) survived the USSR.

2.4 Proliferation of the Global Fund in Ukraine.

2.4.1 Main funders in HIV/AIDS in Ukraine before GF. Other actors in HIV/AIDS

As Marcus et al (2009) pointed out, donor countries and organizations have to a great extent guided the trajectory and implementation of GF programmes at the country level. The section below describes the key funders on HIV/AIDS in Ukraine, whose earlier proliferation had shaped the GF entry.

The UN Family

Historically, the most prominent donor for HIV/AIDS programmes in Ukraine was the United Nations. Ukraine, as a Soviet republic, was a full UN member since 1945, when the decision to allow the USSR to have more than one vote at the UN[43] resulted in Ukraine and Belarus obtaining a UN membership (Bevans, 1968). Despite being nominal, as its delegation voted unanimously with the USSR, the UN membership left an established tradition of Ukraine's involvement at the UN level. When the UN representative office opened in Kyiv in 1992, the country possessed both the experience of international cooperation and a professional cadre of diplomats and international development specialists.

In the mid and late 1990s, HIV-AIDS initiatives clustered around the UN office in Ukraine. They included publication of a bulletin for people with HIV, and support for initiative groups of PLWHA, which began to form an association (UNAIDS 2007). At the end of the 1990s, the UNDP-funded 'Civil society/Government Partnership' programme began to develop multi-sector partnerships in HIV-AIDS policy at the local level. The UN provided assistance to regional governments and civil society organisations to promote their collaboration in organising the response to the epidemic at the regional and local level. A UN Theme Group on HIV/AIDS emerged in 1999, backed by UNAIDS in Ukraine, included UN family organisations, government, representatives of donor projects working in HIV-AIDS, mostly USAID-funded, as well as academics and some NGOs. UNDP supported other HIV-focused projects – such as 'Peer-to-Peer Education in HIV/AIDS' with funding from the Turner Foundation, partnered with a national government agency. In those programmes, the role of NGOs was to seek better ways to influence national and local budget spending on AIDS and to work towards better representing their communities and facilitate their access to state services. With small grants to local NGOs to provide services to the homeless, addicts, sex workers, and other vulnerable populations, UN engagement at this time was marked by a pronounced focus on local and regional governments' role in creating a supportive environment for collaborative, multi-sectoral involvement of non-state sectors of society, formulation of better local policies on HIV/AIDS, and influencing regional budgeting. With UN funding provided for activities, the

[43] The decision to give two republics a UN membership reflected a compromise to appease Stalin, who demanded a separate UN membership for each of the 15 Soviet republics (Axelrod, 2009).

premises and local resources were typically provided by local governments. This was supposed to increase the sense of ownership and make local governments perceive these programmes as their own.

As a UN Security Council member in 2000-2001, Ukraine achieved prominence by supporting several global initiatives, among them the initiation of a UN Special Session on AIDS (UNGASS) that Ukraine announced at the first session of its membership in the Security Council (Kuchinsky, n.d.). Ukraine was also one of the first UNGASS signatories. On the strength of its active support role to UNGASS, reflecting a strong government commitment, in 2001 Ukraine was approached to submit a Round 1 application to the Global Fund.

Soros (Vidrodzhennya) Fund

The other prolific donor to HIV-AIDS programming was George Soros and his 'Open Society Institute' (OSI) in New York. OSI played a very active role in funding civil society groups in Eastern and Central Europe and in former Soviet republics, where 24 of his foundations worked. Aslund (2009) attributed to Soros the development of most nongovernmental organisations in Ukraine. Quigley (1997, p.109) characterised OSI foundations as being "biased toward their own versions of democracy, partisanship, and active involvement in local politics". In Ukraine, Soros operates under the name *Mizhnarodny Fond Vidrodzhennya* (International Renaissance Foundation).

In the mid-1990s, OSI, through its International Harm Reduction Development Programme (IHRD), funded pilot projects in several *oblasts* to work with IDUs and until 2003 was "a key donor" for harm reduction in Ukraine: "It focused mainly on advocacy for drug policy reforms and developing an enabling environment for effective scale-up of harm reduction" (Semigina 2009, p. 22). In 1996, OSI funded the first harm reduction project in Odessa[44]. In 1997-1998, OSI funded NGOs to work with IDUs in Poltava, Mykolayiv, Odesa, Donetsk, Vinnitsa, Zhitomir, Sumy, Simferopol and Kharkov (Zabransky et al, 2012). The initial scale of operation was limited. Later called "boutique programming", the "high-quality,

[44] This project later evolved into the famous NGO *Vyera, Nadyezhda, Lyubov*, mentioned earlier.

small-scale projects" that provided services for most-at-risk populations, were effective "at a very localised level" but had "little impact on the national-level epidemic" (APMG 2009, p. 3).

The first OSI harm reduction projects had a pilot status. In this study, it is assumed that their network in seven *oblasts* formed an initial 'proto-network' of the regional HIV NGOs in Ukraine that later proliferated "beyond boutique level**"** in GF programmes (APMG, 2009, p.14), while the key staff of the OSI IHRD programme moved on to senior management positions with the International HIV/AIDS Alliance in UK and its Linking Organisation in Ukraine, a future GF recipient.[45] These projects had an important role to play in future GF proliferation in Ukraine.

USAID

In 2002, Ukraine was identified as one of 23 USAID priority HIV/AIDS countries globally on the basis of its escalating epidemic and potential for significant economic, political, and social impact (USAID, 2003). The implementers of the USAID programmes were typically US-based contractors. Among the largest recipients were: Futures Group, working though its POLICY project, with a focus on reproductive health and HIV/AIDS policy, and the Seattle-based Program for Appropriate Technology in Health (PATH) that in the 1990s implemented the Ukraine Infectious Disease Program (MEDS, 2000) and later focused on tuberculosis control.

In 2000, unusually for USAID, which typically funded US-based contractors, it awarded funding to a UK-based International HIV/AIDS Alliance for the 'Transatlantic HIV Prevention Initiative' that ran for the period of 2000-2004.

In 2003, USAID introduced 'HIV/AIDS Strategy for Ukraine for 2003-2007.' The strategy introduced a *prioritetnye regiony* ('high priority' regions) policy on HIV/AIDS that directed funding to eight of 24 *oblasts* with the highest HIV rates (USAID 2003). These were Dnipropetrovsk, Donetsk, Kyiv, Mykolayiv, Odesa,

[45]The names and affiliations of the individuals mentioned are on file with the author.

Kherson and Cherkasy oblasts and Crimea Autonomous Republic.[46] ICASO named "the focus on 'priority' oblasts to the detriment of other areas" as one of the challenges to HIV prevention in Ukraine (ICASO 2007, p. 5).

Chapter 5 describes how the GF funding followed the established donor pattern and was also mainly spent in 'high priority' regions.

DFID

The UK Department for International Development (DFID) funded projects in Ukraine as part of **'**Taking Action: The UK Government's Strategy for Tackling HIV/AIDS in the Developing World'. DFID's level of engagement in Ukraine, especially in HIV prevention, was small in comparison with neighbouring Russia, where its programming, "for a range of reasons," was "quite different from others around the world," (DevEx 2008) as noted by DFID Head in Russia and Ukraine Simon Bland.[47] A DFID evaluation by Thomson et al (2007) described the organization's failures in Russia in the area of harm reduction. A notable example was the project in Togliatti, Samara region (1998-2004), which developed an effective HIV prevention programme for high-risk groups, but failed to convince the local government to continue this controversial approach with its own funds. The evaluation concluded that the programme had failed to demonstrate the effectiveness of harm reduction on a large scale and "to influence the Russian government to develop similar public programmes". As a result, DFID "failed to maintain its leading role in the controversial area of supporting NGOs to scale up harm reduction work" (Thomson et al 2007, pp. 36-38).

Reduced DFID involvement in Ukraine may also be explained by the fact that by 2003 the country already had received large funding in R1 from the GF. DFID funding was mainly committed for consultancies aimed at lowering the risk of HIV infection among MSM in Kyiv and Donetsk as well as allocating small grants to in-country NGOs (GOV.UK, 2006). Under the 'Taking Action' initiative, DFID also supported UNAIDS in Ukraine under the 'Building M&E Capacity' rubric. The

[46] The rationale for the choice of the eight regions could not be established from document sources. Other *oblasts* such as Kharkivska with high HIV prevalence were not included. An anonymous agency source suggested that the choice of eight regions was made mainly for political reasons.
[47] Mr. Bland later served as the Chair of the GF Board from October 2011 until mid-2013.

report on ‘Taking Action’ noted difficulties in obtaining disaggregated information on how DFID funds were spent on HIV in Ukraine (GOV.UK, n.d.). DeBell and Carter (2011) suggested the DFID programme had a problematic impact. Allocating small grants to in-country NGOs, each of which was externally managed by UK universities, charities, and NGOs, established a pattern which was “to encourage competitive bidding between small Ukraine NGOs, poor coordination, and a tendency to bypass Ukraine’s MOH. This kind of support not only failed to sustain initiatives but it also failed to confront the fundamental need to strengthen the national health system itself” (DeBell and Carter 2011, p. 9). Stewart called DFID in Ukraine a “prominent departing donor” (Stewart 2009, p.190).

GTZ

The German federally owned technical cooperation enterprise GTZ (Gesellschaft für Technische Zusammenarbeit), in cooperation with the International Labour Organisation (ILO), supported projects in Ukraine aimed at promoting workplace policies and programmes on HIV/AIDS, funded under GTZs BACKUP Initiative (GTZ 2009).The objective of Initiative was to advise governmental and civil society partners on how to apply for funding from the GF and to build their capacity to do so. Particular attention was paid to gender equality, integration into health systems, increased participation of civil society, and capacity development. Project ended in 2009.

Currently called the International Cooperation Enterprise (Gesellschaft für Internationale Zusammenarbeit – GIZ), the agency implements an HIV/AIDS advisory services and institutional capacity building project, ‘Consulting on HIV/AIDS and Support of the Institutions’, commissioned by the German Federal Ministry for Economic Cooperation and Development (BMZ), and executed by the MOH of Ukraine. GIZ is following the ‘Gib AIDS Keine Chance’ (Don’t give AIDS a chance) campaign to promote HIV prevention. Run since 2008, the campaign works to increase knowledge and awareness of HIV/AIDS and improve people’s attitudes to those affected by HIV/AIDS. This applies to the population as a whole, but particularly to adolescents and those who work in ports or for service providers. The campaign engages high profile sport stars to promote healthy lifestyle messages.

The World Bank

The World Bank's US$60 million TB and HIV/AIDS Control Project was funded through its Multi-Country HIV/AIDS Program (MAP). Conceived in 1999, in close collaboration with the Government (UNAIDS, n.d.), this ambitious programme was supposed to reduce TB and HIV/AIDS morbidity and mortality through an effective National Strategy for TB and HIV/AIDS Program. The project became operational in March 2004, with the MOH and State Penitentiary Department as implementing entities (Bank, 2009). The 'AIDS Control' component – to be implemented by MOH - was to support the following objectives: (i) to stabilize the epidemiological situation in the country; (ii) to reduce risky behaviour among young people; and (iii) to reduce the social tension in the society and negative consequences of the epidemic. These objectives were "more reflective of the entire national and international efforts" at the time of project preparation when the GF – the main financier of ARVs in Ukraine was not yet operational (Bank 2009, p. 11). The largest part of 'AIDS Control' component was to be directed towards harm reduction programmes among IDUs, CSWs, and MSM including training, advocacy, education materials, peer education programs, vehicles, syringes, condoms and supplies, as well as providing test kits and equipment to improve blood safety and development of blood safety guidelines. A public awareness campaign was also included for the general population about HIV prevention, to encourage the use of protective measures, and reduce stigma. The programme also provided for HIV treatment activities, development of treatment protocols, drugs and supplies for the treatment of opportunistic infections, training of staff, lab equipment, etc. and for care and support for PLWHA sub-component (Bank, 2009). As noted by Semigina (2009), the GF and the WB programmes were viewed as complementing each other.

The Bank project failed to implement. Funding was suspended numerous times under different governments and Ministers of Health. Geared strongly at TB control and promotion of DOTS, implementation was affected by "considerable resistance to DOTS from the Ukraine's TB Institute"[48](Bank, 2009, p. 9). Part of the problem stemmed from the Bank's own understanding of the TB approaches in Ukraine

[48] Ukrainian TB Institute – a leading institution on TB control. For many years, the Institute has been headed by the influential Academician of Ukrainian Academy of Medical Sciences Yuriy Feschenko.

proposed for Bank financing, found to be "not compliant with international standards" (Bank, 2009, p. 10). The Bank was keen on Ukraine's adopting a TB Programme, as "a crucial transition away from the traditional Soviet approach to TB diagnosis, treatment and monitoring" (ibid., p.10)[49].

The project finally closed in 2008, with most activities never implemented (Bank, 2009). The Bank's own project closure report, describing the main stakeholders, implementation challenges, as well as the political and institutional context that caused the project to fail, informed various stages of this research.

Other actors in HIV/AIDS

AIDS Healthcare Foundation (AHF)

This US-based INGO has come to Ukraine later than most others. AHF is known for its involvement in many HIV programmes globally. In 2011, it was among the harshest critics of the ex-GF Executive Director Michel Kazachkine and called for Kazatchkine's resignation in the wake of reports of "waste, fraud, and corruption" in order that "reforms may begin in earnest" (Reuters, 2011). In contrast to other internationals in Ukraine that advocate a focused HIV prevention and harm reduction, AHF advocated for expanding ART treatment as prevention. AHF became famous for its advocacy activities to expand access to affordable condoms, and free HIV testing throughout Ukraine when it worked with state-run *Dovira* (Trust) cabinets. Through its 'Testing Millions' campaign, in 2010 AHF conducted 18,137 street tests as part of a rapid HIV testing initiative in Ukrainian cities (AHF, n.d.). These screenings generated HIV seropositivity rates of 3.84% (Ford et al, 2012) - three times higher than officially accepted estimates. As part of its advocacy campaign to promote ART treatment, in 2012 AHF wrote a letter to the then GF Executive Manager Jaramillo suggesting that the GF should re-programme its Round 10 funding in Ukraine towards more treatment. The letter noted that access to ART

[49] The Soviet legacy of successfully eradicating tuberculosis before many other industrialised states through establishing a special 'phtisiatry' health care system to deal with TB screening, treatment, and sanatorium cure, continues to influence the modern-day medical establishment in all FSU states.

appeared to be a low priority for the programs supported by the GF in Ukraine[50] and spoke of existing divisions over funding priorities in-country between GF PRs who argued that its grants focus on prevention, while government money should be spent on treatment: "The Global Fund's efforts to promote prevention should not come at the expense of more than 100,000 people who are waiting for treatment. The number of people dying of AIDS is growing and the epidemic is spreading", the letter said. HIV cannot be stopped unless everything is done to test PLWH, provide ARVs to all who need them and bring the viral load in HIV positive people to undetectable levels - all of those to be done, according to AHF, to follow GF own Board recommendations issued in May 2011. Without such re-programming, AHD reiterated, "millions of GF dollars in Ukraine could go to waste". The AHF campaign did not succeed to alter the GF funding focus in Ukraine.

Clinton Foundation

Former US President Bill Clinton's Foundation worked in Ukraine within a framework of the 'Clinton Global Initiative' (CGI). The CGI – "a unique model to unite and guide opportunities of individual persons and organizations in order to implement change" (Pinchuk Foundation. n.d.2) was financed by Victor Pinchuk, a "Ukrainian tycoon, a son-in-law of that former Soviet republic's authoritarian president" [Kuchma] (Baker and Savage, 2008). According to *The New York Times*, Pinchuk has given $1-5 million to Mr. Clinton's foundation and agreed to underwrite a Clinton initiative to encourage philanthropy in developing economies in Asia, the Middle East and Africa (Thomas, 2008). The project would have consisted of a series of conferences presided over by Mr.Clinton, as well as other activities. The receipt of funding from "a billionaire who made his money during the controversial privatization process of Ukraine's steel industry" (Thomas, 2008) was not revealed by Clinton until December 2008, when under pressure from Obama presidential team he disclosed his foundation's donor list – in order to confirm Hillary Clinton's nomination as Secretary of State (Nasaw, 2008). The new administration was concerned that among the donors to the Clinton foundation were some representing

[50] The AHF letter is on file with the author.

conflicts of interest for Mrs Clinton in her role as Secretary of State (Zaleski, 2008). The Obama administration in December 2008 signed a memorandum of understanding with the Clinton Foundation, which required Mr. Clinton to disclose his past donors and any future contributors. The memorandum also required that in case of Mrs. Clinton's confirmation, the CGI should be incorporated separately, could longer hold events outside the US and would refuse any further contributions from foreign governments (Baker and Savage, 2008). As a result, the project funded by Victor Pinchuk, was discontinued.

Partnered with Clinton Foundation was another prolific funder in HIV/AIDS in Ukraine - 'ANTI-AIDS' (ANTI-SPID) Foundation, founded by Elena Pinchuk, the wife of Victor Pinchuk, and a daughter of the ex-President Leonid Kuchma. Queen Elisabeth II, the former UN General Secretary Kofi Annan, and Sir Elton John are among the dignitaries who have participated in the ANTIAIDS Foundation projects. Among the Foundation's activities were HIV awareness campaigns in media outlets owned by Victor Pinchuk, work in orphanages for HIV-positive children, Sir Elton John's concerts and others.

2.4.2 The GF entry to Ukraine. Strong government support

As mentioned above, Ukraine's active role in initiating the UNGASS special session in 2001 positioned the country as a regional leader of the global fight against AIDS. Ukraine was approached by donor states to submit a proposal to the GF, and its R1 application was approved shortly.

Ukraine was the first among the post-Soviet states where the GF signed three grant agreements of R1 grant in January-March 2003for a period of five years. The USD 99.12 million in R1 was seen as significant contribution to Ukraine's fight against AIDS. Andrij Pidaiev, Minister of Health of Ukraine, said at the signing: "We are proud of this and will pursue the policy of true partnership in the response to the epidemic in Ukraine" (GFATM 2003a).

As one report suggested, "having been a 'first mover' carries a cost" (Brusati 2003, p.5). Ukraine's price for its early GF submission turned out to be very high.

The original R1 proposal was developed under the aegis of MOH and was consolidated from several parts for which separate submissions were encouraged. Overall, there is lack of publicly available information on the pre-Round 1 submission procedures and the first year of the programme. The original proposal at the GF web-site (Ukraine Portfolio n.d.), a report on CCM prepared by Brusati (2003) and the OIG 2008 review of the suspension of GF grants were used in writing this section, as well as Roger Drew (2004-2005) reports.

The official submission was made by the newly established Country Coordinating Mechanism – the Government Commission on Fighting HIV/AIDS headed by the Vice Prime-Minister of Ukraine (at the time, Vitaly Seminozhenko). This CCM's membership was large – a GNP+ report noted it having 45 members, as well as the use of "silent" selection criteria in the process of appointing CCM members (GNP+ 2003, p. 6). R1 proposal was submitted at a time when the Global Fund had just defined the very concept of the CCM (Brusati, 2003), and before clear CCM guidelines had been developed (Drew, 2004). Brusati (2003) noted that even after the R1 programme commenced, none of the CCM stakeholders interviewed for his study were aware of the existence of the GF's CCM Guidelines issued on June 4, 2003, while the CCM itself proved to be "an important testing ground for Ukraine" (Brusati 2003, p. 24). Later studies found programmes approved in the GF Round 1 were weaker than subsequent ones, since the GF systems were not initially fully in place (Radelet and Siddiqi, 2007).

The three Principal Recipients (PRs) for Ukraine's R1 proposal were the MOH (responsible for roughly 70% of the grant with the goal to implement treatment, care and support of HIV/AIDS patients), UNDP (in charge of 10% of the grant focused on HIV prevention programmes), and the Ukrainian Fund against HIV/AIDS, a GONGO [51] , (responsible for 20% of the grant focused on information/education campaigns [IEC] for the general population). Intended results for the MOH component included: antiretroviral therapy and therapy for

[51] GONGO – government-organised NGO. The Ukrainian Fund to Fight HIV/AIDS was established by Directive of the Cabinet of Ministers No. 1620 of November 29th, 2001, 'On Establishment of the Ukrainian Fund to Fight HIV/AIDS', as a 'governmental NGO' reporting to the Cabinet of Ministers. (Brusati, 2003, p. 14)

opportunistic infections for 1,500 PLWHA, the number of infected babies born to HIV-positive women reduced by 10 per cent; 50 per cent of pregnant women to be treated with ART, to prevent mother-to-child transmission. Intended results for the UNDP component included: coverage of IDUs by prevention programs is increased to 20 per cent in identified sites, use of sterile syringes is increased to 50 per cent, use of condoms by sex workers while providing services is increased to 30 per cent, use of condoms by men in uniform is increased to 40 per cent (GFATM 2003a).

The Ukrainian Fund was responsible for management of the CCM Secretariat; and its Chair served as CCM Executive Secretary (Brusati, 2003). The OIG 2008 review reports that an assessment of the three PRs by the the Local Fund Agent (LFA)[52] found all of them to have limited (i.e. UNDP and MOH) or no capacity (The Ukrainian Fund) to implement GF programs. Grants were signed on the premise that capacity would be developed during grant implementation. The decision to allow the PRs time to build capacity ran "counter to the GFATM model of having time-bound and performance-based grants" (OIG 2008, p. 13). The prevailing geopolitics of the time led the GF to violate two of its own guiding principles in order to enter the second-largest ex-Soviet country: it accepted the proposal from CCM that did not meet its own guidelines, and awarded grants to PRs without capacity to implement. This was not the last time the GF would not fulfil its guidelines in Ukraine.

Implementation stalled soon after it started in spring 2003 because there was no pre-existing capacity to absorb such a massive grant. The MOH, a "rain forest" of bureaucracy, had no official mandate, no clear lines of authority to authorise spending and other dysfunctional arrangements (World Bank 2009). As a result, GF money was not being spent. After nearly 12 months of a 24-month program, the recipients had spent less than 4 % of the total amount of the three grants (OIG 2008). The OIG sought to understand why the LFA, which was to oversee the in-country implementation, had not notified the GF Secretariat about the issues in country. The LFA acknowledged knowing about capacity issues in country, but said it had not included them in its reports because they had to "adopt a diplomatic stance in their

[52] LFA in Ukraine was the auditing firm PricewaterhouseCoopers (OIG, 2008)

written opinions" and "had to be mindful of their position in the country". This ran counter to the declaration of independence that is signed by all LFAs in undertaking their work (OIG 2008, p.14).

Meanwhile, with CCM "clearly in a state of flux" (Brusati 2003, p. 24), a new structure emerged - the 'NGO Secretariat on cooperation with the Global Fund in Ukraine' ('NGO Secretariat'). 'NGO Secretariat' was directly funded by a R1 Sub-Recipient, the International HIV/AIDS Alliance, which provided facilities, equipment, and staff salaries and support for an electronic bulletin (Brusati, 2003)[53]. Despite being structured as an informal civil society forum, the name 'NGO Secretariat on cooperation with GF in Ukraine,' translated into local language, suggested that this structure may have been endorsed by the GF or linked to it. While the dysfunctional CCM and its Secretariat, the 'Ukrainian AIDS Fund' struggled with grant administration and had to rely on state-salaried clerks, well-funded and fluent in English 'NGO Secretariat' had many advantages in regard to information dissemination, and their electronic bulletin soon became the "most comprehensive source of information about the contents and decisions of all key meetings linked to the country-level activities of the Global Fund" (Brusati 2003, p.16). A poll that the 'NGO Secretariat' conducted in May 2003, challenged the MOH as a Principal Recipient, stating that "some of the leading Ukrainian NGOs have been working in the area of HIV/AIDS without interruption since the mid-nineties, long before the MOH began to deal systematically with the disease"(ibid., p.17). The questionnaire was distributed among organisations from the database of the 'NGO Secretariat,' and only ten NGOs responded, suggesting the circle of organisations involved was narrow. While the ten respondents were anonymous, as Brusati reported, having been chosen through the USAID-funded Alliance database, they most likely included regional NGOs - implementers of the ten 'boutique' projects in the 1990s, a 'proto-network' of regional AIDS NGOs mentioned above. Despite the small number of respondents and the disclaimer that the poll did not intend "to identify the results

[53] Brusati appears to have been misled about the GF funding going through Alliance to support 'NGO Secretariat'. Since the GF money was not being spent at that time, it looks more possible that 'NGO Secretariat' was funded through a USAID project that Alliance implemented at the same time. The address of 'NGO Secretariat', listed on the NGO Poll (Brusati 2003, p.55) is the same as the USAID-funded Alliance office in Kyiv.

with the opinion of all HIV/AIDS-servicing NGOs", the 'NGO Secretariat' was invited by the GF to present the poll results at its Regional Meeting of 12 countries of Eastern Europe and Central Asia (Brusati 2003).

2.4.3 Suspension of Round 1. Transfer of the R1 grant to the INGO

In late January 2004, a GF mission led by its Chief of Operations arrived to Ukraine, shortly after the GF Secretariat received a letter from several NGOs, whose identity has not been officially disclosed by GF. According to OIG (2008), the allegations received were about:

(1) possible payment of kickbacks to MOH officials from prospective sub-recipients (SRs), and
(2) the price of the selected bidder for ARVs being US$3.1 million higher than the lowest bidder and that two other lower bidders had been disqualified (OIG 2008, p. 13).

The OIG 2008 review further reports that the GF Secretariat hired forensic accountants Ernst and Young (EY) to investigate the allegations. The EY report contained recommendations for improving internal controls, but "did not conclude on the existence of irregularities" (OIG 2008, p. 13). The GF ordered another review from its LFA[54], which concluded that the winning bidder was a dormant company with no known operations and directors based in Cyprus. This second review also did not confirm the allegations of irregularities in the letter that sparked the investigation. The GF then ordered the MOH to cancel the tender and to appoint UNICEF to procure ARV drugs. According to the OIG, the decision to select UNICEF was undocumented. UNICEF submitted a bid that was subsequently revised four times, resulting in a bid that was about US$ 1 million higher than the bidder selected by the MOH. The OIG report, while not disputing the rightness of the bid cancellation, nevertheless defined the GF Secretariat decisions as "being contrary to [the GF] principle of having country-led processes because they: (a) contravened procurement best practice by intervening in an ongoing procurement process; and (b) contravened one of the basic [GF] principles by instructing the MOH to procure from UNICEF"

[54]Price Waterhouse Coopers.

(OIG 2008, p.14). The Ukrainian government tried to challenge these moves, but events began to escalate quickly.

Following the January 2004 mission, GF suspended the Ukraine grants citing "poor governance by the CCM, poor management by the PRs, lack of clarity of internal procedures and slow program implementation"(OIG 2008, p.15). This was the first country grant suspension in GF history. On January 30, 2004, the GF Executive Director Richard Feachem, noting that firm action was needed to ensure the ambitious targets for treatment and prevention of HIV/AIDS in Ukraine could be reached, said: "The primary responsibility of the Global Fund is to achieve results and to turn back the HIV/AIDS pandemic. We have taken action with our colleagues in Ukraine in order to ensure that our money flows, that the epidemic does not spread further, and those who need treatment will receive treatment"(GFATM, 2004a).

The suspension carried with it a set of conditions, among them:

(a) Selection of an organization that would temporarily replace the three PRs "until the CCM could address the slow implementation and decide on other PR arrangements";

(b) Cancellation of the MOH tender;

(c) Establishment of a monitoring and advisory unit; and

(d) Resolution of governance and management issues at the CCM level (OIG, 2008, p. 16).

On February 24, 2004, the GF announced the end of the grant suspension and the appointment of a temporary principal recipient. The International HIV/AIDS Alliance – a UK-headquartered INGO that had been a SR in R1 – was appointed as Temporary Grant Steward. A GF press release announcing the appointment anticipated that the Fund would allow Ukraine to resume leading project management once issues related to "governance, management, and adherence to required business practices are satisfactorily addressed"(GFATM, 2004b). The OIG 2008 review noted the GF failed to document its decision making, providing no explanation of what alternatives were considered by GFATM to resolve the crisis, how the decision was arrived at, and why it was the optimal decision. Another OIG

report noted the GF's decision to suspend the grant and pass stewardship to an international NGO was "controversial" (OIG 2012b, p. 10).

The GF Secretariat also placed Ukraine on the Additional Safeguards (ASG)[55] list. The OIG concluded that the decision to place Ukraine on the ASG list was made by the country team [at GF Secretariat] based on the risks arising from the previously discussed weaknesses of the three initial PRs and the CCM. Again, however, the OIG noted that the GF had failed to document its decision to place Ukraine on the ASG list (OIG, 2008). The decision of placing Ukraine on ASG further led to the selection of Alliance as a temporary grant steward. The OIG 2008 report noted that the [GF] Secretariat's justification of its selection was based "on the grounds of a strong track record in HIV program implementation, sound management arrangements and a strong presence in Ukraine" (ibid., p.17). However, no evidence was advanced that there were no other institutions in Ukraine that could satisfy the GF criteria. UNAIDS underlined that "donor preferences for using well-established international NGOs rather than local organizations has hindered opportunities to strengthen the latter's capacity" (UNAIDS ASAP 2009, p. 44). Although the GF "took steps to consult stakeholders about the decision to suspend the grants and to appoint the Alliance as Grant Steward, these were ultimately the Global Fund's decisions" (Drew and Malkin 2005b, p. 3).

The swiftness with which the GF arrived at its decisions regarding the R1 transfer and Grant Steward appointment[56], accompanied by lack of documentation about in-country processes, as noted by OIG, was remarkable for an organization that did not have a country presence. The decisions were justified, not based on country ownership mechanism, but in a flurry of communications from the GF and International HIV/AIDS Alliance about the need to proceed quickly and urgently so "that the epidemic does not spread further, and those who need treatment will receive treatment" (GFATM 2004a). The fact that Alliance initially was made responsible for a one-year stewardship contract, brought in a 'short-termism' approach,

[55] The ASG is part of GF risk-management strategy, which is invoked when existing systems cannot ensure accountable use of GF financing. The GF Secretariat applies the ASG as required based on the facts and circumstances of each particular grant (OIG 2008).

[56] The decision to appoint the Alliance as Grant Steward was taken «within two to three weeks of the decision to suspend the original grants" (Drew 2004, p. 20).

characterised "by the need for urgency and meeting challenging deadlines", and "a constant tension between following procedures correctly and getting things done on time" (Drew 2005a, p. 11). The narrative of 'urgency' and 'emergency' would become a dominant theme for the whole period of the Alliance as a grant steward, as well as in later GF implementation years.

2.4.4 Aftermath of the suspension. Further GF rounds

The OIG (2008) review noted that while the conditions (a) and (b) of the GF suspension were quickly met by withdrawing funds from old PRs and nominating a new implementer, the other two conditions, (c) establishment of a monitoring and advisory unit, and (d) resolution of the CCM governance and management, aimed at ensuring governance of the GF grant during and after the transition, were not met. The NAC (CCM) did not survive the grant suspension and was disbanded. A period of government walk-out of all multi-sectoral AIDS structures ensued.

Instead, International HIV/AIDS Alliance began holding 'Stakeholders Meetings' in March 2004 that replaced government engagement. These became 'by default' the major HIV/AIDS coordination mechanism in Ukraine (Drew 2005c).

The GF decision to transfer money to an INGO was strongly opposed by the government (OIG 2008). "It undoubtedly affected the Ministry of Health's willingness to see the Global Fund-supported program as part of the national response" (Drew 2005c, p.4).

In March 2004, the GF entered into a one-year contract agreement with Alliance under which the R1 funding was transferred to Alliance, which agreed to provide stewardship and management services for activities under the three suspended grant programs. The new agreement had four components, (i) treatment, care and support (57%), (ii) targeted prevention (15%), (iii) IEC (12%), and (iv) surveillance and evaluation (3%). The remaining 11% was earmarked for the PR unit to manage the grant execution (Bank, 2009). Thus the government priorities reflected in the original R1 allocation – 70% to implement treatment, care and support of HIV/AIDS patients, 10% focused on HIV prevention programs, and 20% for

information/education campaigns [IEC] for the general population - were significantly revised by GF and Alliance with no Government involvement.

The focus of this grant was the provision of ARV therapy for treatment of HIV/AIDS (APMG 2009). The programme's strategy focused on supporting and expanding community-based prevention and care interventions for vulnerable and hard to reach communities, and providing up-to-date and tailored information and resources. Integral to this approach were linkages between prevention and care and support services (Semigina 2009).

The OIG review (2008) noted the model adopted in Ukraine ran contrary to several cardinal GF principles like promoting national ownership and additionality:

> The Global Fund finances national programs through participatory proposal development processes, including multiple stakeholders, processes that complement existing national and/or regional programs, that support national policies and priorities. (GFATM 2001, p.4)

The OIG suggested that NGO management of GF grant posed several challenges:

(a) being seen as a stand-alone project as opposed to being part of the national AIDS program, implying lack of national ownership with minimal government commitment and support (also noted by Drew 2005c); and

(b) Alliance's focus on delivering results and meeting targets left "little time for considering …issues like coordination and building a national response" (OIG 2008, p. 19).

Notably, an important aftermath of the GF grant transfer in Ukraine was an increased debate at the GF about how to ensure accountability for its investments. The pressure to disburse funds rapidly overwhelmed efforts to scrutinize recipients more carefully or manage financial risks more fully. Established in July 2005 at the behest of the donors, the Office of the Inspector General (OIG) has been "*the only risk-mitigation strategy within the Global Fund that has worked as designed"*(High-Level Panel 2011, p. 53). [emphasis added]

According to the Stewardship agreement with the GF, Alliance implemented the first phase of R1 programme until 30 September 2005. In May 2005, a R1 extension proposal was submitted on behalf of Ukraine by a newly formed CCM, the

National Council on AIDS. The new Grant Agreement with the GF acknowledged that "the Alliance was nominated by a group of stakeholder representatives and endorsed by the Ukrainian National Coordination Council on the Prevention of the Spread of HIV/AIDS" (GFATM, 2005). The OIG noted the decision to nominate Alliance as PR for the new grant was made without a review of its performance, under the 2004 stewardship agreement (OIG 2008).

The next GF round for which Ukraine submitted an application was R6. International HIV/AIDS Alliance in Ukraine was again nominated as a PR in R6 by Ukraine's CCM. The R6 application set ambitious goals that some stakeholders believed might be difficult to achieve in practice (Semigina, 2009).

With the receipt of R6 grant, International HIV/AIDS Alliance in Ukraine became the largest GF recipient in East and Central Europe. The co-Principal Recipient in R6 was the All-Ukrainian Network of People Living with HIV/AIDS (*Merezha*), a Sub-Recipient in R1. Its nomination was not without questions. Being a national advocacy organization, known for its criticism of the government, many questioned whether *Merezha* would have the capacity "to handle such massive responsibilities while also continuing to advocate effectively on behalf of people living with HIV— and to do so with its customary independence" (UNAIDS 2007a, p. 7). Sustainability of GF programmes run by two NGOs was also in question:

> The systematic lack of Government involvement and support for programmes and activities implemented by NGOs also represents a serious risk to their short-term results and long-term sustainability. (UNAIDS 2009, p. 31)

2.5 International NGO as a Principal Recipient: narrow focus and challenges of legitimacy

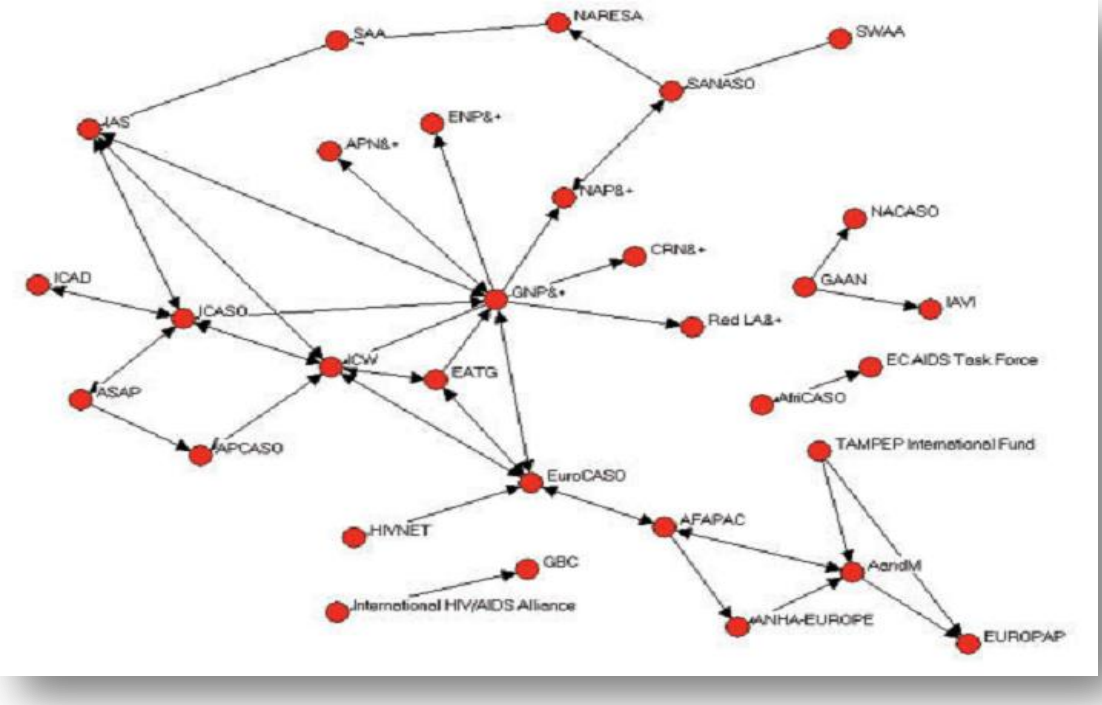
As discussed in Chapter 1, the core issue in the GF agenda is to engage civil society and those affected by the diseases.

Much of the global discourse on AIDS and NGOs is acknowledged as having developed along the lines of a 'North-South' relationship, with the slow recognition of the phenomenon in the political science and international relations literature (Boone and Batsell, 2001). O'Manique (2004) and some others have argued that the public health response to AIDS in the West was shaped by a 'neo-liberalism's

triumph', with its view of health as largely a private and individual responsibility. Involvement of the medical research establishment and pharmaceutical industry determined largely a biomedical approach to policy response to AIDS in Sub-Saharan Africa, which she called "the hegemonic biomedical understanding of African AIDS" (ibid., p. 66). Others, while seeing correlations between Structural Adjustment Programmes (SAPs), and the growth of HIV/AIDS epidemics, stopped short of drawing a clear causal link (Barnett and Blackwell, 2004).

Nelson suggested a 'North–South divide' across NGOs, corresponding roughly to developed versus less developed countries (Nelson, 2002). Shumate et al (2005,p. 488) described the 1990s as "an era of great success for HIV–AIDS INGOs", manifested in activist issues being recognized by the international community, and increased aid funding becoming available. Their study examined partnerships within the global HIV–AIDS INGO community (see Figure 2.16):

Figure 2.16 A myriad of global alliances of HIV–AIDS INGOs (Shumate 2005, p.499)



Among the activities that INGOs conduct, Shumate et al identified exchange of ideas, promotion of member interests, coordination and regulation of member activities, education and public awareness, research and information gathering, and

humanitarian activities. The authors asserted that INGOs typically work "within the status quo" to provide services and to advocate for their members (Shumate et al 2005, p. 486).

Risse (2006) discussed the issue of INGO legitimacy in the context of governance, noting frequent accusations of INGOs for lacking legitimacy. He suggested that the issue was linked to INGOs' internal accountability and concluded: "if we compare 'INGOs' to democratic states, they certainly lack internal accountability" (Risse 2006, p. 190). Smith (1997) noted that most transnationally operating NGOs were accountable to a rather small group of members and to those who fund them, mostly private foundations, and often public agencies.

In Ukraine after 1991, expectations were high that civil society organizations would emerge to deal with HIV:

> The breakdown of the Soviet system has led to a gap in society that is normally occupied by 'civil society' and the construction of this will be difficult and slow, yet it is crucial in halting and responding to the epidemic. In particular people living with HIV are marginalised and excluded. Experience elsewhere shows that they have a vital role to play in developing policies for intervention and support services. (Barnett and Whiteside 1999, p. 216)

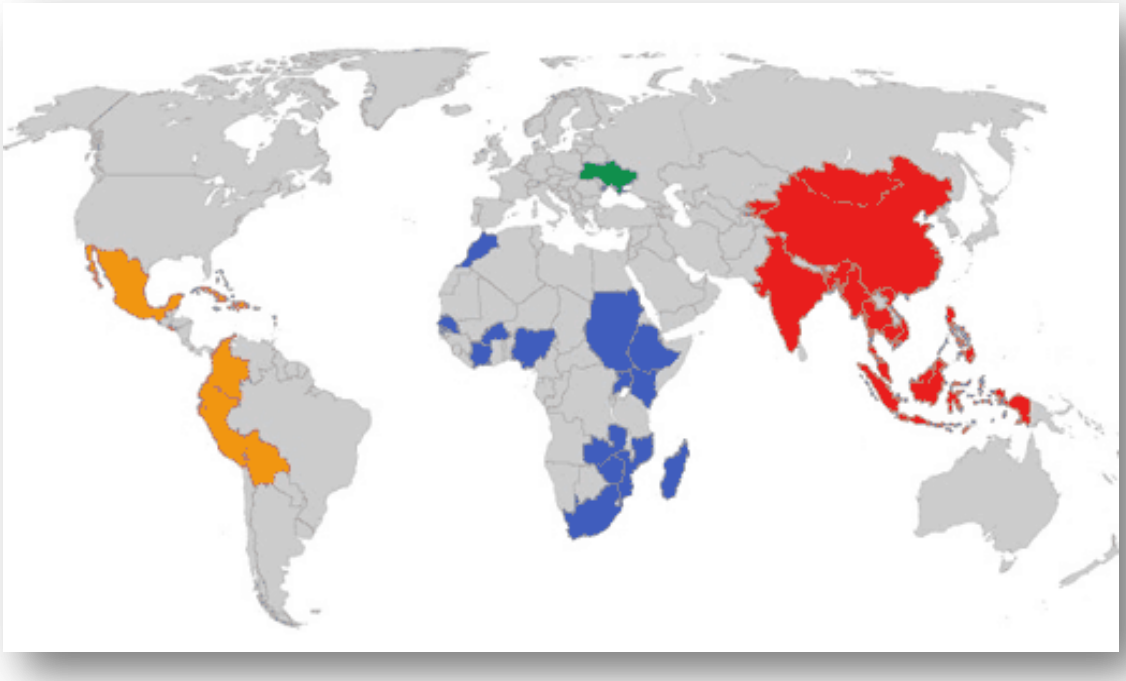
However, the way AIDS NGOs proliferated in Ukraine did not originate from a post-communist transition discourse. While their onset was slow in comparison with the post-1991 development of other civil society actors, when they emerged as the 'proto-network' of AIDS NGOs, they were externally funded, developed mainly around external discourses, and advocated narrowly for policies associated with these interventions. Zhukova (2013) argues that the direction of funding has been a major determinant shaping the NGO sector in HIV/AIDS in Ukraine. She places a discussion of HIV/AIDS in context of "transnational governmentality" and defines the "NGOisation of the HIV/AIDS sector in Ukraine as a process involved in establishment of the transnational apparatus for discourse production and dissemination of expert knowledge on the epidemic" (Zhukova 2013, p. 96).

While in other Eastern European countries, for most NGOs working on HIV prevention, the need to secure funding occurred "on the landscape of political and

moral messages regarding HIV and the need to serve their clients" (Owczarzak 2009, p.422), Ukraine's NGO context was profoundly altered by the GF entry. Not only there was little domestic discussion about political and moral messages of HIV – but the fact that the money was given directly to the INGO by the GF, demonstrated that this NGO did not emerge or developed internally in Ukraine, neither was its recipient status a result of a wide local initiative or a call for civil society participation.

The UK-based International HIV/AIDS Alliance began work in Ukraine in 2000 with USAID funding. The International HIV/AIDS Alliance-Ukraine became a separate legal entity in March 2003, after it obtained a local registration from the Ministry of Justice with the Secretariat of the International Alliance in the UK as a founder. In R1, it operated as a country office (OIG, 2012). In 2009, Alliance in Ukraine became an 'independent Linking Organisation' (Alliance, 2010). Through its Linking Organisations and country offices, International HIV/AIDS Alliance accesses GF funding in more than 30 countries in the world (see Figure 2.17). In the FSU, Alliance works only in Ukraine.

Figure 2.17 Alliance Linking Organisations receiving GF funding (Alliance. n.d)[57]



[57] The use of colours in this map is merely to distinguish between the continents and sub-continents where Alliance or its Linking organisations are implementing the GF-funded programmes: yellow to

Soon after R1 funding was confirmed, International HIV/AIDS Alliance in Ukraine pronounced itself "the largest NGO in Ukraine. Its current size stems primarily from the appointment, in March 2004, of the UK-based International HIV/AIDS Alliance as Principal Recipient of the country's Round 1 HIV/AIDS grant" (International HIV/AIDS Alliance 2007, p. 35). An organization positioning as the largest national NGO, made this claim merely because it was a subsidiary of a foreign NGO and a recipient of GF funds. This mostly self-appointed mandate was carried on by this organisation with the continued support from the GF. The GF decision to nominate an INGO to implement grant in a country with a developed civil society and existing HIV/AIDS governance structures has left many gaps in understanding the context of this decision as well as its further impacts on governance and country ownership of HIV control in Ukraine.

Conclusion

Ukraine's country context and its previous Soviet history are important in understanding the complexity of the environment in which donor programmes have come to deliver aid. Regarding HIV epidemic, the multiplicity of political, economic and social factors that contributed to its spread in Ukraine, warn from seeing it simply as a preventable and treatable disease, as existing political and criminal contexts need to be considered when discussing what interventions to control HIV would have had the greatest impact. The prevailing perception of the HIV transmission in Ukraine as occurring mostly via injecting illicit drugs had important implications for the choice of HIV prevention interventions.

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denote South America, blue to denote Africa, green – for Europe and red – for Asia. In Europe, Alliance only works in Ukraine.

CHAPTER 3: HOW THE RESEARCH AGENDA WAS FORMED: PHILOSOPHICAL, EPISTEMOLOGICAL AND METHODOLOGICAL PERSPECTIVES OF THE RESEARCH. THE CHOICE OF RESEARCH APPROACH. DATA COLLECTION AND DATA ANALYSIS.

Introduction

The chapter begins with the review of the key document sources and other data on GF that were used in research. The chapter then continues with the discussion about theoretical underpinnings of this research and positions it within a wider philosophical and epistemological perspective. The discussion then proceeds to outline the positions taken by the author on the ontological issues, epistemological and axiological assumptions that underpin qualitative research. By justifying and describing the choice of methodological approaches and research tools that were applied, it asserts the place of this research within the existing paradigms. The chapter concludes by describing data collection in more detail, including the researcher's reflection of the experiences during field work and research limitations. The final part describes the process of data analysis and details its stages.

3.1 Literature review: Available sources of information and data on Global Fund

i. Search time limits

For the purpose of keeping information up-to-date, and because of the rapid changes in HIV/AIDS policies, epidemiological updates, and amendments to the GF policies, the search timeline was established between 2002 (year of the creation of the GF when most establishing policies were adopted) and 2012 (the last year of implementation of the Round 6 GF grant in Ukraine). Besides, most global AIDS policy approaches were amended around 2001-2002 (UNGASS Declaration, etc.) which further supports the timeline limitations. Some timeline exceptions were made, as new relevant literature and documents emerged in 2013, both internationally and in Ukraine.

ii. Keywords and selection criteria

Standard search engines generate up to 300,000,000 hits for 'Global Health' and up to 1,300,000 results for 'Global Fund to Fight AIDS, Tuberculosis and Malaria'. The preliminary literature search used the following databases: GoogleScholar, PubMed, Scopus, Cochrane Library, EBSCO, as well as links to Reports and Publications at the WHO, UNAIDS, UNDP, and the GFATM sites. For specific, country-related information, specialised databases were consulted including: HIV/AIDS Survey Indicators Database, CIA World Factbook, and GF, WHO, UNAIDS, UNDP, World Bank country pages. For Ukraine's government documents, CCM materials and links the web-site of Ministry of Health of Ukraine, and State Services on HIV/AIDS website were consulted. Reference lists of the relevant literature were also searched. Titles and abstracts were searched for the following terms: 'Aid programmes in former Soviet Union', 'Foreign aid for HIV/AIDS', 'aid effectiveness', 'The Global Fund to fight AIDS, Tuberculosis and Malaria', 'GFATM', 'HIV/AIDS policy', 'HIV prevention', 'HIV programmes research', 'HIV/AIDS epidemic in Ukraine', 'NGOs in FSU countries', 'AIDS NGOs', 'HIV services', as well as combinations of these terms.

iii. Publications review: the place of Global Fund among other global health initiatives. Global Fund in Ukraine.

Since its inception, the work of the Global Fund has been subject of numerous research and analysis. Publications stem from Principal Recipients annual reports, independent evaluations conducted by the experts hired by the GF, to scholarly articles and US Congressional reports.

Literature reviewed included the published primary sources on the topic, published between 2002 and 2012 identified through PubMed, Medline, and Google Scholar search engines, as well as general, predominately political science literature on post-Soviet studies. In order to inform the exploratory research study, I searched for published abstracts and papers related to the HIV epidemic and GF in Ukraine. The literature review was intended to identify specific sources on the GF implementation in Ukraine. More papers were added to the literature review as they

appeared while the research was in progress. A limited list of literature sources on GF was done by the author before the start of the PhD research to originate the research proposal. This list was further expanded to include the following categories of sources:

1) The official GF web-site served as the primary source of reference for GF policies, information on Ukraine's grant portfolio, as well as a linking page to GF Publications. After 2011, there were problems in accessing GF documents: some links were no longer active, or previous information updated by new, including alterations of grant amounts and disbursements. Previously saved files were used for analysis, where available. Cross-references were made to other sources citing GF documents web-pages.

2) Reports of the GF Office of the Inspector General (OIG). OIG produces regular reports of planned or diagnostic audits that measure the effectiveness of GF spending. Two reports in particular were used in analyzing implementation in Ukraine – the OIG 2008 Report on suspension of GF grants, and the OIG 2012 report (a draft version circulated to CCM members, and the final official version were available). Other OIG reports and statements were used when writing about GF general policies and systems.

3) U.S. government reports. Among the consistent analysis of the GF, are periodic reports of Congressional Research Services (CRS) and Reports of the U.S. Government Accountability Office (GAO) to the US Congress. CRS reports dated between 2002 and 2010 contained a comprehensive analysis of history and political environment of the GF, analysis of GF procedures and structures, funding disbursements, and outlined bottlenecks and lessons learned from country experiences. GAO 2005 and 2007 reports were used that were commissioned by members of Congress before hearings on aid disbursement. They represent well-documented evidence to assess Global Fund's efficiency.

4) The web-site of the US-based think-tank 'Center for Global Development' (CGD), 'HIV/AIDS Monitor' reports[58] and 'Global Health' blog were periodically reviewed

[58] http://international.cgdev.org/initiative/hivaids-monitor

for references, as well as publications of their key associated authors such as W.Savedoff, S.Radelet, A.Glassman, N.Oomman, and some others.

5) The World Bank Independent Evaluation Group (IEG) reports. IEG is charged with evaluating the activities of IBRD and IDA (the World Bank), to assess the performance of Bank Group policies, programs, projects, and processes (accountability) and to learn what works in what context (lessons). The IEG evaluations of the GF informed Chapter 1.

6) The GHIN (Global Health Initiatives Network) database[59] was a source of GF-centred publications including their study of GF in Ukraine by Tatyana Semigina.

7) Web publications of the 'Aidspan' – an NGO with headquarters in Kenya, such as GFO - Global Fund Observer - that provides regular updates and analysis on the GF Board meeting decisions, OIG reports, as well as author's publications with the analysis of the GF policies and programmes.

Specifically in regard to GF in Ukraine, following sources were consulted:

1) Annual reports, grant manuals and grant documents of two Principal Recipients located at the web-sites of International HIV/AIDS Alliance in Ukraine and the All-Ukrainian Network of PLWHA *(Merezha*). PR documents in local language were also consulted that were circulated during stakeholders and other meetings in Ukraine attended by the author. At mid-stage of the research, web-sites were updated a number of times and some document links became inactive, however, most documents are in downloaded form in the author's files.

2) Synergy Working Group/Roger Drew reports. Under the auspices of Synergy, in 2004-2005, at the end of the first year of the Global Fund stewardship agreement implemented by International HIV/AIDS Alliance, USAID commissioned consultant Roger Drew to conduct a series of evaluations in Ukraine on GF implementation. These reports, released during GF Round 1, represent an important source of evidence about the GF implementation policies and practices in Ukraine,

[59] The GHIN (Global Health Initiatives Network) database is the outcome of a systematic search for research on three HIV/AIDS Global Health Initiatives (GHIs): the Global Fund, the World Bank's Multi-country AIDS Project (MAP) and the President's Emergency Plan for AIDS Relief (PEPFAR): http://www.ghinet.org/database.asp

describe country context, service delivery practices, and outline implementation challenges. This source was of a special importance as it focused on topics that later also emerged from the data analysis. Drew reports are referenced across the whole thesis and contain important insights into the PR systems and policies in Ukraine.

3) Country reports generated or commissioned by donor programmes based in Ukraine: such as the MEASURE Report funded by USAID in 2011, and others that describe the implementation systems and practices of the Alliance in Ukraine.

4) WHO Ukraine country assessments of various years, including EuroWHO 'Health systems in transition' reports, were used to write about health care system in Ukraine and other sections.

5) UNAIDS reports: Ukraine's country UNGASS reports, evaluation reports by UNAIDS – such as 2009External Evaluation of Ukraine's National Response on HIV/AIDS. Commissioned on behalf of the Ukraine's government -that also had a focus on GF programmes. Other UNAIDS annual reports on HIV epidemic globally and regionally, relevant country reports and web-page publications were consulted.

6) The 2009 report by Australia-based AIDS Projects Management Group (APMG). Commissioned through the GF-funded tender by Alliance, APMG conducted an evaluation of prevention services implemented by Alliance as a GF PR in terms of their efficiency, quality, cost benefit and sustainability potential. The APMG evaluation was believed to be generated for the GF extension of Phase 2 of R6 Alliance grant and contained important insights into GF programme delivery 'on the ground'.

7) The World Bank 2009 closure report. The report about a failed World Bank project that was implemented at the same time as the GF R1 and R6 programmes, contained important evidence about political and health care context of aid programmes in Ukraine, and about specific in-country implementation policies and practices.

8) Documents of the National Council on HIV/AIDS and other socially dangerous diseases (CCM) proceedings, including paper documents handed out at the CCM meetings that were shared with the author by individual CCM members or otherwise made available to the author when attending CCM meetings. The full list of Ukraine's official sources consulted is included into the reference section.

9) Unpublicised documents that were available to the author in-country through personal communications, and various other communication means including stakeholders listserves, conference presentations, meeting minutes, communicated memos, disseminated statements etc.

More publications relevant to a particular part of my study, are referred to in the concrete section where they are cited. Media sources were used in describing the GF crisis in 2011.

3.2 Philosophical, epistemological and methodological perspectives of the present research

The section below carries on the discussion about the research theoretical underpinnings and positions it within a wider philosophical and epistemological perspective. It starts with outlining the major philosophical traditions that guided the field of social studies and justifies the choice of the qualitative research as a preferred methodological tradition. The discussion then proceeds to outline the positions taken by the author on the ontological issues, epistemological and axiological assumptions that underpin qualitative research, and establishes the choice of ethnographical enquiry as a preferred research approach.

3.2.1 Key philosophical traditions in social studies and the choice of qualitative research for this study

> Science should not be necessarily a mystery nor a monopoly of experts and intellectuals.
>
> Fals-Borda, 1995

The philosophical approaches to social studies follow two distinct traditions of thinking. Historically, positivism, a recurrent theme in the history of Western thought, holds to the view that the only authentic knowledge is that which allows verification and assumes that the only valid knowledge is scientific. Positivism came to replace metaphysics in the history of knowledge, mainly through the works of the Enlightenment philosophers, among them Henri de Saint-Simon and Auguste Comte, the latter is attributed with the development of the modern sense of the positivist

approach. A philosopher and a sociologist, Comte argued that, much as the physical world operates according to gravity and other absolute laws, so also does society. Positivism is marked by the final recognition that science provides the only valid form of knowledge and that facts are the only possible objects of knowledge; philosophy is thus recognised as essentially no different from science. Politics, social interactions, and all other forms of human life about which knowledge was possible would eventually be drawn into the orbit of science (Kieran, 2007).

At the turn of the 20th century, social scientists began to challenge the justification of utilizing the scientific method of the physical sciences to study social and human matters (Onwuegbuzie, 2000). In contrast to Comte's positivistic ideology, Wilhelm Dilthey's interpretive/hermeneutical approach to science emerged as the first serious challenge to positivism. Dilthey noted that whereas the physical sciences dealt with inanimate objects that often exist independently of human beings, the social research focused on the processes and products of the human mind (Hodges, 1952) and therefore should not be conducted with the methods of the physical sciences due to a fundamental difference in subject matter. Max Weber, greatly influenced by Dilthey (Bergstraesser, 1947), thought that both research paradigms had significant shortcomings: positivism could not attach meaning to a social reality, whereas idealism did not entertain the possibility that a social reality might be the existing reality. Weber expressed the need to focus social inquiry on the meanings and values of acting persons and therefore on their subjective meaning complex of action. Weber's solution to Dilthey's problem was to attempt to bring together the positivist and interpretivist paradigms (Onwuegbuzie, 2000), however he did not succeed in this task as noted by Outhwaite (1987). These two paradigms remained polarised beyond WWII.

The times of social change, civil rights and liberation movements of 1950s and 1960s were marked by the emergence of post-positivism (e.g., Hanson, 1958; Popper, 1959). Post-positivists asserted that reality is constructed and that research is influenced by the values of investigators. Post-positivism gave birth to more radical paradigms such as constructivism, interpretivism, and naturalism. Many theorists representing these new iconoclastic paradigms began to argue for the superiority and

exclusiveness of post-structuralism and post-modernism (Onwuegbuzie, 2000). These idealists believed that multiple-constructed realities (i.e., relativism) abound, that time- and context-free generalisations are not possible, that inquiry is value-bound, that it is impossible to distinguish between cause and effects, that logic flows from specific to general, and that knower and known are inseparable.

The tendency to lean toward more interpretive, post-modernist, and critical practices research became dominant in social studies in recent years. Qualitative research has also been characterised by a growing interest to studying the narrative practice. This "narrative turn" is producing a significant literature as researchers present sensitising concepts and perspectives that bear especially on narrative practice, which centers on the circumstances and communicative actions of storytelling. Riessman (1993) and Gubrium and Holstein (2009) provide analytic strategies and methodological frameworks for narrative analysis, and Holstein and Gubrium (2011) present the variety of approaches in recent comprehensive texts.

Qualitative rather than quantitative research methods were adopted in this research. Numerous strengths of qualitative data have been outlined by Miles and Huberman (1994), among them a focus on naturally occurring, ordinary events in their natural settings. They further maintain that qualitative data are “fundamentally well suited for locating the meanings people place on the events, processes, and structures of their lives, and for connecting these meanings to the social world around them” (Miles and Huberman 1994, p. 10).

Cresswell (1998) suggests that the rationale for an individual willing to engage in qualitative inquiry can be found among: (1) the nature of the research question, (2) the need to explore a particular topic, (3) the need to present a detailed view on the topic, (4) because it allows the researcher to study individuals in their natural settings. He suggests the following definition of qualitative research:

> Qualitative research is an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting.(Creswell, 1998, p. 15)

3.2.2 The worldview/paradigms of research

Cresswell believes that qualitative researchers approach their studies with a certain paradigm or worldview, a basic set of beliefs or assumptions that guide their inquiry. These assumptions are related to the nature of reality (the ontological issue), the relationship of the researcher to that being researched (the epistemological issue), the role of values in a study (the axiological issue), and the process of research (methodological issue) (Creswell, 1998, p. 74).

Guba and Lincoln (2005) distinguish five main paradigms of the qualitative research, namely:

- positivism,
- postpositivism,
- constructivism,
- critical theories, and
- participatory paradigms.

Within these research paradigms, this study follows a constructivism, by Guba and Lincoln (2005), or a constructionism, by (Crotty 1998) research paradigm, with a symbolic interactionism as its theoretical perspective. George Herbert Mead, the father of symbolic interactionism, believed that humans should be understood in terms of their behaviors. Mead's view of "a person" as "a personality because he belongs to a community, because he takes over the institutions of that community into his own conduct" (Mead 1934, p. 162) is methodologically significant. It means that when the research is done from this perspective, we have to take, to the best of our ability, the standpoint of those studied on the situation and articulate the viewpoint of the actors we are studying clearly and accurately. To serve the aims of the present research, ethnographic enquiry was adopted as a research paradigm.

Below I summarise the main philosophical assumptions made by me that guided this research.

The ontological assumptions taken by the author considered the existence of multiple research realities: that of the researcher, those of individuals being investigated, and those in the reading audience who would be interpreting the study. It was believed that this research needed to report these realities and the best way to achieve it was by generating extensive quotes, presenting emerging themes that were based on the words used by informants themselves, and collecting advance documentary evidence for the different perspectives on each theme. The choice of qualitative research interviews as a method of data collection for being "attempts to understand the world from the subjects' point of view, to unfold the meaning of peoples' experiences, to uncover their lived world prior to scientific explanations" (Kvale, 1996) suited this purpose well.

In regard to epistemological assumptions, i.e. those that determine the relationship of the researcher to that being researched, the need to minimize the "distance" or "objective separateness" (Guba and Linkoln 1988, p.94) between the researcher and the researched was viewed as a necessary prerequisite for this research. It was supposed to enable to generate relevant and diverse data from within a variety of settings and from different levels of informants. The author had prior work experience in the field of international organisations in Ukraine which were the main factors facilitating access to informants. The choice of the ethnographic inquiry with its focus on the researcher spending significant time in the field, observing interactions between the researched subjects was justified in this regard.

As to the axiological assumptions i.e. the values that the study supports, those were seen as related to the epistemological assumptions that assumed initially the close distance between the researcher and the researched. This study was conceived from having a critical perspective on the work of international aid organizations in the FSU, and throughout the thesis, the 'critical space' was maintained to enable the researcher to construct a more holistic and comprehensive picture of the GF aid model delivery in Ukraine. Regarding the interpretation of the interviews, it was believed that less iteration of the author's own position needed to be achieved, and for this a balance between the personal beliefs of the author and the opinions expressed by the participants, needed to be maintained. This was done through using

coding and applying the contextual analysis in interview analysis, in which the themes that emerged from participants' accounts, formed the framework through which the data analysis and discussion were carried out. More explanation of the data collection methods is provided further in the present chapter.

3.2.3 Research design: choosing among the five traditions

Within qualitative research, John Creswell's (1998) outline of five main research traditions, namely: biography (originated in historical studies), phenomenology (with origin in psychology), grounded theory (originating from sociology), ethnography (from anthropology) and case study approach from political science, constituted a departure point in choosing a research approach to guide my enquiry.

As noted above, the current aid discourse of the Global Fund and its implementers in Ukraine remains partisan, and their narratives typically present Ukraine as a 'success story'. Meanwhile, many gaps remain as to the effects of the GF programme implementation by NGOs, in particular: how the NGO implementation affected health services delivery, what were its effects on the HIV care continuum, on NGO roles and relations in the 'Third sector' in Ukraine, and in other GF-funded settings. The quest to examine how the GF aid delivery model worked in Ukraine, coupled with the existence of a 'pre-charged' GF programme environment and a politicised country context, described in Chapter 2, called for a more holistic and a more encompassing approach that would best position the researcher in accessing the data and respondents in country, allow for the least compromised position to facilitate access and building trust with participants, in order to obtain a solid evidence for the study.

Two of the abovementioned theoretical approaches were considered for this study, namely the case study approach and the ethnographic inquiry approach. Following below is argumentation of the relevance of these approaches for this study.

Yin defines the case study research method "as an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the

boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used" (Yin 1994, p. 23). He believes the choice of the case study method is determined by:

1) The type of research question: typically to answer questions like "how" or "why";

2) Extent of control over behavioural events: when investigator has a little/no possibility to control the events;

3) General circumstances of the phenomenon to be studied: contemporary phenomenon in a real-life context (Yin, 1994).

Case studies, in their true essence, explore and investigate contemporary real-life phenomenon through detailed contextual analysis of a limited number of events or conditions, and their relationships.

Some characteristics of the phenomenon to be studied (the GF), the country of study (Ukraine) and time-line of the Rounds 1 and 6 programme corresponded to one of Yin's characteristics – i.e. *contemporary phenomena in a real-life context* – which could potentially justify for a choice of a case study research design. Case study research design was also considered for its ability to define the research topic broadly, to cover several variables and to rely on multiple sources of evidence. Important consideration for the case study method included the context being seen as a major part of a study. And lastly, case study was considered for being frequently used in the studies of programmes. As noted by Parthasarathy, "case studies of specific programs, projects, initiatives, or sites, have become integral to evaluation research to analyze the implementation processes and outcomes" (Parthasarathy, 2008).

3.2.4 Ethnographic enquiry as an enabler for 'critical space' to study aid

At the same time, other features of the research phenomenon suggested that the object in view was not just a case, but a manifestation of what may also be viewed as a distinct 'culture' – the culture of aid giving – encompassing multiple networks and inter-relations, and occurring in varying country contexts. Chapter 1 discussed existing dilemmas in aid research, when donors, being powerful decision

makers, exert significant influence on the discourse in aid debate. Because of an often partisan nature of this discourse, creating a research environment for conducting an independent study of aid is a task far from easy. To look into donor-funded activities and study the aid delivery processes, the need is crucial to create a research environment that would allow including a broader scope of views to be reflected, including those that may not necessarily be positive accounts.

This suggested considering another relevant approach: that of a critical ethnographical inquiry. As Creswell (2007) has argued, the critical ethnographer examines the culture through the lens of power, privilege, and authority in response to an ethical responsibility to address unfairness or injustices and attempts to achieve positive social change (Brown & Dobrin, 2004; Hammersley, 1992). The choice of a critical methodology positions the researcher to examine social inequities, with a goal of creating positive social change. Madison (2005) observed that the criticalist moves from "what is" to "what could be" (p. 5) to contribute to emancipatory knowledge and the discourses of social justice.

It is this ability to maintain a 'critical space' that I found so indispensable in regard to ethnographic enquiry when I sought to best position myself as a researcher. The need to have a method of inquiry that would allow to capture more broadly the voices 'from the ground', including critical voices, is paramount in order to have a realistic look into the aid delivery process. Establishing a more 'critical space' for my research was also necessary in order to question, following Easterly and Williamson, whether the GF performed the way it said it would – as it is the "key question in the aid effectiveness debate" (Easterly and Williamson, n.d., p. 6).

In addition, I felt the need not to just draw a picture of one case of aid delivery in a particular case country – Ukraine – but to demonstrate how global power relations (of the GF with Ukraine) profoundly shaped local relations (of GF Principal Recipients with other actors and systems in country). Doing this meant observing relations that appeared during the GF aid model delivery, among them that of the 'giver' and of the 'taker', as well as reflect on the participants' perspectives on the aid process. In order to be able to observe and record the interactions, the

researcher needed to be positioned as close as possible "to take the role of others" (Crotty 1998, p. 83), "to take the standpoint of those studied" (Denzin 1978, p. 99).

I believed that ethnographic enquiry represented the most appropriate approach that would enable me to reflect the voices of actors who otherwise would not be included into most of the donor-guided and donor-influenced studies.

To serve the aims of the present study, ethnographic enquiry was adopted as a paradigm of research, because its main purpose was to enable the researcher "to uncover meanings and perceptions on the part of people participating in the research, viewing these understandings against the backdrop of the people's overall worldview or 'culture'" (Crotty 1998, p. 7). Ethnographic approach was also identified for allowing "to look for patterns, describe local relationships (formal and informal), understandings and meanings (tacit and explicit), and try to make sense of a place and a case in relation to the entire social setting and all social relationships" (Parthasarathy, 2008).

Ethnography also seemed appropriate taking into account the author's familiarity and experience with aid organisations in Ukraine which might bear some inherent biases. In such conditions, the advantage of ethnography was seen, following Hammersley (1985,p. 152) in enabling the researcher to treat the "familiar social settings" to be studied "as anthropologically strange" in which the task for the researcher was "to document the culture – the perspective and practices – of the people in these settings".

Several studies that have provided a useful guidance and facilitated finalising the choice of ethnographic enquiry as a primary research approach are reviewed below.

3.2.4.1 Ethnographic enquiry as a means to describe aid giving culture

Ethnography, which literally means to "write (or represent) a culture"[60], traces its origins to ancient Greece and a "father of history" Herodotus whose *History*

[60]Ethnography (from Greek ἔθνος *ethnos* = folk/people and γράφω *grapho* = to write) the scientific description of peoples and cultures with their customs, habits, and mutual differences. (Oxford Dictionaries).

investigated the origins of the Greco-Persian Wars and included a wealth of geographical and ethnographical information. Herodotus explored the Middle East as the centre of the world which he believed was torn apart by the tensions between two civilisations: Eastern and Western, Persian and Greek (Clair 2003). This division is revisited by post-colonial scholars (Ashchroft 1995; Castle 2001), and post-modern scholars (Clifford and Marcus 1986). Ethnography has its earliest roots in social anthropology, which traditionally focused on small scale communities that were thought to share culturally specific beliefs and practices (Savage 2000). Overall, the traditionalist view on ethnography as a master discourse of colonisation is outlined by Robin Clair (2003) who lays out the four phases of ethnography and takes to task the colonial underpinnings of ethnographic practices. Political change, both globally and within the academic world, has meant that the ethnographer's authority to provide the only, or most legitimate, account was no longer accepted (Ahmed and Shore 1995).

A strong case in favour of making international aid a part of ethnographic discourse was made by David Mosse and David Lewis in their volume *The Aid Effect: Giving and Governing in International Development* (2005). They describe the expansion of the scope of ethnography from "its classical concern with 'the local' and 'the other' or *the impact of global processes on local places*, to more sophisticated conceptions of local-global relations" and outlined "the fruitfulness of an ethnographic approach to aid" (Mosse and Lewis 2005, p. 1).[emphasis added] Among the questions they pose to describe the challenges "the global aid architecture" presents, some are relevant to the aims of this thesis:

> How are relationships (international, state-citizen) reconfigured in the contemporary transnational aid domain? Are boundaries between nation-states, donors and self-governing international financial institutions (such as IMF and the World Bank) blurred by the new technical demands of managing aid flows? Does the 'moral resurrection of aid' with its emphasis on ownership, participation and good governance in fact conceal an era of greater intervention by international agencies in the internal affairs of developing countries? (Mosse and Lewis 2005, p. 2)

Bierschenk (2000) notes that neo-liberal trends to denationalise and decentralise aid serve to diversify further sources of power and influence via a proliferation of organisations and intermediary networks. The multiplicity of

interactions in development gives this field of anthropology a "privileged empirical pathway" into social reality, as noted by Mosse and Lewis, since it forces attention to the social processes and negotiations of meaning and identity in heterogeneous social arenas. Moreover, Mosse and Lewis (2006, p. 1) believe that it is no longer possible to isolate interactions in development from those in state apparatus, civil society, or wider national or international practices; in their words, "an anthropology of development is inextricably an anthropology of contemporary Africa, Latin America, and Asia".

Gille and Ó Riain (2002), speaking of the challenges posed by globalization to existing social scientific methods of inquiry, referred to "global ethnographers" who, by locating themselves firmly within the time and space of social actors "living the global," can reveal how global processes are collectively and politically constructed, demonstrating the variety of ways in which globalisation is grounded in the local (Gille and Ó Riain 2002, p. 271).

At the same time, as noted by Laëtitia Atlani-Duault, taking an 'insider' ethnography is both to carry out a 'multi-situated ethnography' (Marcus 1995), or 'global ethnography' in which the local and the global are mutually constitutive (Burawoy et al 2000), and to participate as fully as possible in the community being studied (Bellier and Wilson 2000), the latter implying trying to blend in with the group.

Institutional ethnography approach, an empirical approach to inquiry combining theory and method developed by Smith (2005) was also considered in relation to this study. Unlike traditional case study research, institutional ethnography does not aim to generalize from or compare local phenomena. Although the initial point of entry is the examination of local phenomena, the end goal of an institutional ethnography research project is to expose how larger power relations shape local experience. Slade (2010) suggested that institutional ethnography projects can be framed as extended case studies into the mechanics of power. Institutional ethnography is an important tool for understanding social organisation and developing strategies for activism to effect social change.

3.2.4.2 Ethnography to study post-communist transition and aid programmes in FSU

Chapter 2 described post-Soviet transition and its political, economic and social effects. As shown by many authors, the post-Soviet transition has also created, exacerbated, and redefined forms of difference and inequality throughout the region, and anthropological and epidemiological research on the spread of HIV reveals that it is precisely these inequalities that structure the distribution of disease risk and burden (e.g., Schoepf 1998; Rhodes et al 1999). Owczarzak highlights the importance of ethnographic research in studying HIV vulnerability, for its ability to reveal "the relationship between complex sets of interrelated "vectors of disadvantage" (e.g. underemployment, lack of social services, and lack of personal safety) and HIV vulnerability" (Owczarzak 2009, p. 422). Important in relation to the present study was her argument that the trend in HIV prevention research in post-socialist contexts ignored these inequalities and downplayed historically produced social exclusions and marginalization in favor of prevention programs that reify culture and focus on information dissemination and choice.

"Pioneering work on Western aid to Eastern Europe", as described by Brown (2006, p. 16) was marked by Steven Sampson (1996, 2003), Thomas Carothers (1999a, 2004) and Janine Wedel (2001). Sampson described "the social life of projects" as a "specific set of resources, people and practices" that flow between West/North and East/South and "ultimately create embedded interests". Sampson described the formation of new 'project elites' – groups and organizations competing for money, influence, access and knowledge (Sampson, 2003) as an outcome of aid programmes. Wedel (2001) undertook an ethnographic approach to study aid programmes in Eastern Europe ad FSU – to see "how aid happens – through whom and to whom, under what circumstances, and with which goals" (Wedel, 2001, p. 6). In a later publication, Wedel defines her methodology as "studying through... tracking policy discourses, prescriptions and programs and then linking them to those affected by the policies" (2005, p. 37). Wedel's major contribution to the aid research is her account of aid to Poland and Russia, and she describes in detail the impact of Western assistance, delivered there over a short period of time by

organisations and individuals with little knowledge of the social, cultural and political contexts in which they were operating. A special focus is made by her on 'transactors' – those entrusted with managing the transfer of resources. Later, Sneed (2006) acknowledged Wedel's work as coming back to fundamentals of development research by Robert Chambers who was calling for moving beyond traditional hierarchies of knowledge and expertise, implicated in the 'top-down' model of development (Chambers 1997). Chambers critique is now more widely accepted as implying that international development initiatives often "import value systems and principles into local systems, disrupting social, political and other power structures on the ground with the end goal of transforming local culture and social behaviour" (Sneed 2006, p. 102). In Sneed's view, Wedel applied this critical ethnographical tradition in analysing Western aid in Eastern Europe and FSU, which had the effect of creating a new plutocracy. The work of Thomas Carothers (2004, p. 5), a renowned expert of post-communist transitions, advocates strongly for the ethnographic approach when he speaks about "listening as carefully and systematically, as possible to what a wide range of people in developing and postcommunist countries say about the experience of being on the receiving end of democracy promotion policies and programs".

Alexandra Hrycak (2007) and Martha Kichorowska-Kebalo (2011), both of whom focused on Ukraine and dealt with the effects of the US aid programmes on women's organisations there, have chosen ethnographic enquiry for its ability to reflect on post-Soviet transitions and their impact on organisations, institutions and self. Kichorowska-Kebalo's study of the post-Soviet women's movement in Ukraine "sought ground in both anthropological and feminist theory as self-consciously political as well as intellectual systems of thought" (Kichorowska-Kebalo 2011, p. vi), while Hrycak called for "careful ethnographic study" to research how transnational activists move across borders as 'a fruitful starting point' to analyse the relationships "between global and local forms of women's mobilization in Ukraine"(Hrycak 2007, p. 76).

Another insight into the world of post-Soviet aid was made in a book by Laëtitia Atlani-Duault *Humanitarian Aid in Post-Soviet Countries: An*

Anthropological Perspective. The author depicts "the confrontation that occurred between Soviet and Western models when faced with a shared social phenomenon: the promotion of a development model" (Atlani-Duault 2007, p. ix). With rich experience working with a major international agency in the FSU region, Atlani-Duault defines her research as a "networked ethnography, from within" (ibid., p.5). She stresses the importance of bringing into the development discourse not only the simplistic vaunting of the knowledge of "'the people', an idealized entity, irretrievably poor and oppressed, which needs to be defended"(Olivier de Sardan 2004, p. 729), as populist critical anthropologists would do (an approach that she associates with the work of Chambers (1997); or a dismantling of a 'neo-colonialist' discourse of development as a "top-down, ethnocentric, and technocratic approach" (Escobar 1994, p. 44), as deconstructive development anthropologists do, but a 'third approach'. In her perspective, rather than considering development as an external force acting on 'real ethnological' field subjects, Atlani-Duault, following Mosse and Lewis (2005), suggests that development workers are themselves valid subjects for fieldwork. She further asserts that "development situations are 'interfaces' not only between field actors but also between the institutions they represent and the representation systems that influence them" (Atlani-Duault 2007, p. 5).

In designing this study, I found strong parallels with Atlani-Duault's perspective of a developmental worker and of 'development situations' suggesting a more focused 'insider' ethnography. This position of the researcher within a researched subject was very close to the experience I brought with me when I started my research at Queen Margaret University, after more than fifteen years of work with aid programmes in the FSU region. Although not without an inherent bias, this position provides a researcher with a unique lens of looking into the aid practices through their own experience, and I considered myself well-positioned in this regard. In particular, adopting an 'insider' look proved a valuable approach during data analysis, when making inferences from participants' responses required a thorough understanding of the implementation realities on the ground.

3.2.4.3 Other theoretical concepts informing this research

This research uses the ethnographic enquiry to better understand the complex transnational processes of combating the HIV epidemic, in which individuals, organisations, policies, and values constantly interact. It aimed to establish how the GF aid model manifested itself in the roles, relations, systems, and practices that appeared in the process and at the result of the implementation of the GF Round 1 and 6 programmes by Principal Recipients NGOs, using the example of HIV prevention programmes.

At the initial stage, this research was also informed by other theoretical concepts, such as policy implementation theories, aid evaluation research, health policy analysis and post-Soviet studies. The latter one in particular had assisted in contextualisation of my research and provided a background for viewing the GF programmes within historical, economic, political and social contexts of HIV in post-Soviet Ukraine. Chapter 2 reflects in detail on the country contexts of Ukraine and its HIV epidemic as an outcome of post-1991 transitions, and describes background in which aid programmes have developed. This part of the study was informed by works of Medvedev (1999), Feschbach and Galvin (2005), Twigg (2007), Rowland and Telyukov (1991), DeBell and Carter (2005) and some others.

The works of Murray Feshbach, the Western world's leading expert on Soviet and post-Soviet health and demography, provided important accounts of the counterproductive USSR policy responses during the early days of the HIV epidemic. DeBell and Carter (2005) underlined the importance of understanding the context for those doing research in the post-Soviet region.

The role of the country context is of a particular importance for this study that looks into the effects of GF aid for HIV/AIDS control in Ukraine, and views them through the prism of the post-Soviet policy environment as "markedly different from that in southern Africa, southeast Asia, and other poor regions where HIV has ravaged societies" (Twigg 2007, p. 20). While in many parts of the world, the effective response to the epidemic was hindered by poorly developed health systems, and money for HIV response had to be channelled in absence or with insufficient infrastructure and workforce necessary to deliver the services, Ukraine's existing specialised AIDS health care system begs considering an alternative approach.

Within the country context of Ukraine, the following dichotomy is shaping its HIV/AIDS response: while its institutional capacity is framed by "the perverse horizontal segmentation" that characterized the previous Soviet health care system (Twigg 2007, p. 21), the choice of HIV control measures is rooted in external recommendations based on the understanding of health service delivery in the developing world. This dichotomy helped to contextualise this research and assisted in the choice of the theoretical approach.

There were other relevant issues that affected the choice of theoretical approaches:

- Lack of research base for policy making in Ukraine

The discipline of social research is developed in Ukraine, with much human and institutional expertise is present, however, DeBell and Carter (2005) highlighted weak or non-existent links between policy making and social research institutions. The unclear link between policy and research in post-independence Ukraine presents additional challenges when researching national policy on HIV/AIDS. Lack of national research base was noted by participants when they described how target setting for HIV prevention was done using external approaches by PRs in R1-R6. More details are provided in Chapter 4.

- Donor dictum in HIV/AIDS policy in Ukraine

The fact that donors practice "coercive policy transfer" (Hudson and Lowe, 2009, p.87) by which transnational institutions "almost dictate the nature of policy change", is well-established on the example of African countries by Moyo (2009), and in analysing the donor aid for privatisation in Russia by Stiglitz (2001), Wedel (2001) and others. As Marcus et al (2009) point out, core principal policies from donor countries and organizations have guided to a great extent the trajectory and implementation of GF programmes at the country level. There is, however, little discussion about a 'coercive policy transfer' in regard to aid programmes in health care that are implemented in post-communist countries, and in particular in Ukraine.

Rather, the focus of many donor programmes is on criticising post-Soviet state health care, which is blamed virtually for everything in regard to aid delivery,

with some arguments stemming from an old Cold War discourse, and others informed by a neo-liberal World Bank paradigm. Despite the fact that the Soviet Union has not been in existence for more than twenty years, the legacy of 'Semashko' health care continues to haunt neo-liberalist aid policy thinking. The criticisms are even more ominous because post-Soviet health care, having suffered after 1991 "the most astounding collapse in public health ever witnessed in peacetime in the industrialised world" (Garrett 2000, p.113), was further weakened by neo-liberal market reforms, as discussed in Chapter 2. The critical narrative of post-Soviet health care as incapable of health service delivery serves to justify why the aid programmes deliberately aim at by-passing the state health system in favour of non-state providers and in favour of narrow health focuses.

As noted above, the 'blame the government' narrative has prevailed during the GF programmes delivery in Ukraine. The persistence of this narrative has often directed the debate about the impact of GF into a stovepipe of politically motivated discussion about post-Soviet health care and its problems. With the focus on criticising the government as ultimately responsible for providing health care services, the GF own 'zone of responsibility' is obscured, including how GF-funded programmes shape the way HIV health services are practised, whom the services are reaching and how roles and relationships develop in GF-funded health settings.

In these circumstances, the role for the researcher is to describe and document, and be a reflexive observer who witnesses the aid processes in the making, observes how different players interact, and describes their relations. For these reasons, the author believes that ethnographic inquiry constitutes the most appropriate research approach in the given research context. The fruitfulness of an ethnographic approach looks particularly attractive in view of the nature of this research, which aims to study the Global Fund globally conceived aid delivery model, and roles, relations, policies and practices that appear during the GF programme implementation in their local context in Ukraine – i.e. to determine the "impact of global processes on local places" (Mosse and Lewis 2005).

Based on the foregoing, the present research is defined as a critical ethnographic enquiry into the conduct and practice of INGOs and national NGOs in

their role as Principal Recipients of GFATM grants targeting HIV prevention during Rounds 1 and 6 programmes in Ukraine (2003-2012). In particular, it looked into the GF core models – such as NGO-based delivery of services, performance-based funding and 'country ownership' governance manifested through Country Coordinating Mechanism (CCM) – and studied how they were perceived by participants on the ground. All of the above aspects of GF engagement with Ukraine are critically analysed to determine how the GF aid delivery model affected its HIV prevention policies and services.

3.3 Data collection stages

This study adopts research methods that are generally common to qualitative research, employing a holistic approach to problem-solving, rather than relying on a single method for collecting and analysing data, and thus employing a triangulation of methods. Within the data, the distinction between secondary and primary data was made. *Primary data* was collected through the 50 in-depth, semi-structured interviews with key stakeholders with experience in GF programmes in Ukraine. *Secondary sources of data* included various published literature sources and country documents with specific information on HIV prevention and GF programmes in Ukraine, as well as notes made of participant observations at the venues such as CCM and stakeholder meetings. The observation notes were used in conjunction with emerging themes from the participant interviews and were synthesized in the analysis.

50 interviews were conducted between November 2011 and September 2012 with purposively selected participants based in Kyiv, and during field visits to three oblasts of Ukraine. The interviews were all transcribed into text.

The document analysis comprised key GF programme documents – annual reports of the PRs; minutes of CCM and stakeholder meetings; GF, PR, and government press releases; and other available documents on the web-sites of the GF, State Service of Ukraine for AIDS and Other Infectious Diseases, the Ukrainian Centre for Disease Control and two PRs.

Document analysis commenced prior to regional interviews and continued during the interview phase and after the end of data collection, as new sources became available. Some relevant documents were uncovered during trips to oblasts in the process of interviewing, and were also included in the document review. Some sources represent unpublicized reports that were obtained by the author during in-country meetings and through online communications, and are on file with the author. PR operational manuals, guidelines, grant competition announcements, as well as databases GF SRs were also reviewed on the web-sites of the two PRs or obtained during Stakeholder or CCM Meetings in Ukraine attended by the author. Both electronic and paper versions of CCM documents were reviewed as they were available on the State Services web-site and notes from the selected CCM sessions that the author attended in 2010, 2011 and 2012 in Kyiv were also used.

3.3.1 Designing an interview guide and choosing key interview areas

Qualitative research interviews are "attempts to understand the world from the subjects' point of view, to unfold the meaning of peoples' experiences, to uncover their lived world prior to scientific explanations" (Kvale, 1996). In qualitative research, open-ended responses to questions provide the researcher with quotations, which are the main source of raw data. According to Patton (1987, p.11), quotations "reveal the way in which [the respondents] have organized the world, their thoughts about what is happening, their experiences, and their basic perceptions…The task… is to provide a framework within which people can respond in a way that represents accurately and thoroughly their point of view about the program".

Patton identified three main types of qualitative interviewing to use in research: the informal conversational interview, the interview guide approach, and the standardized open-ended interview. Although these types vary in the format and structure of questioning, all of them have in common the fact that the participant's responses are open-ended and not restricted to choices provided by the interviewer. A fourth type of interview, the close-ended, fixed-response interview, falls in the realm of quantitative interviewing, and was not considered for this research. A limited number of closed questions was nevertheless included into the Interview

Guide to obtain views on Ukraine's epidemic, effectiveness of GF programmes, and to define the respondents status and GF experience.

The Interview Guide approach was adopted for use in my research for being the most widely used format for qualitative interviewing. This approach was seen as enabling the interviewer to cover an outline of topics or issues, while allowing for some freedom to vary the wording and order of the questions. Another benefit of using the interview guide was seen especially in cases of possible 'deviations' from the main themes, if the need would arise during an interview to probe for more in-depth responses. It was also expected that this format of interview will still remain fairly conversational and informal as I aimed to establish a good rapport with my study participants and gain their confidence. A possible drawback of using the interview guide approach was noted by Sewell (1999) who suggested that sticking to the outlined topics will prevent other important unanticipated topics from being raised by the respondent. The interview guide was believed to be flexible enough to enable the balance between covering the main areas and allowing to probe into the respondent's specialised or contextualised knowledge and explore new issues and ideas that might come up, with due discipline and time management exercised by the researcher during interviews.

Face-to-face interviews were the preferred method. Previously distributed information sheets (in Appendix G), and a brief introductory session preceded each interview during which participants could find out more about the researcher and the research and were asked to sign the consent forms.

The Interview Guide addressed the following main thematic areas:

(1) Questions to determine respondent's status, length of experience and level of knowledge about GF programmes. Those included: sector to which a respondent belonged, length of GF experience or specialized knowledge, type of work involved in connection with GF programmes.

(2) The main bloc of questions – to be asked of all participants:

a) Status of Ukraine's HIV epidemic

b) Entities/institutions responsible for HIV prevention

c) Defining prevention interventions funded by the GF

d) Assessment of the Principal Recipients' roles in HIV prevention
e) Assessing the roles and effectiveness of the CCM.

(3) Bloc of questions on HIV prevention needs and coverage: how they were determined, what decision making mechanisms existed, main actors in target setting.

(4) Questions about the influence of the GF programmes in Ukraine:

(5) Questions about the organisation and documentation of HIV prevention services – asked to participants with HIV service delivery experience. Central to this segment was the assessment of whether and how often, NGOs in the studied regions offered to their clients from vulnerable groups HIV prevention services and how clients were categorised and counted.

The full Interview Guide is provided in Appendix H.

3.3.2 Fieldwork organization

As Suter (2012, p. 350) notes, the sampling plan for gathering text is often purposive, meaning that participants are selected to serve a specific purpose (not randomly to allow generalisation across a population), and the purpose of the sampling plan is "to maximize the value of data for theory development by gathering data rich enough to uncover conceptual relationships".

The need to look deeper into the GF programme implementation strongly suggested that because of the perceived complexity of those programmes and their inherent focus on specific interventions, the number of people possessing specialised knowledge and experience was limited to a certain number of individuals and organisations in Ukraine. It was therefore the nature of the research question that determined the choice of respondents to be studied. The need for more in-depth investigation of the HIV prevention services delivery and the relations that occurred in the GF-funded settings required that a portion of participants should have been interviewed in *oblasts*. Regional probe into the GF programmes implementation was meant to provide my study with regional dimension and serve to solidify its conclusions.The final sampling plan therefore included sampling by participants'

geographical region, by sector identity and level of experience/involvement with the GF programmes.

3.3.3 Geographical location and criteria for their selection

Given time and resource constraints, the focus of the research was on three regions plus the capital city of Kyiv. In sampling geographical territories for the research, following factors were considered:

1) Official epidemiological data of the registered cases of HIV infection at the oblast level (from Ukrainian Centre for Disease Control). The map showing HIV prevalence in various oblasts of Ukraine is presented in Chapter 2.

2) The extent to which GF programmes were present in oblasts. Data on geographical distribution of GFATM-funded HIV prevention services taken from PR annual reports was used to determine this.

3) Considerations of Ukraine's regional differences also played a role; one region represented Western Ukraine, one Southern Ukraine and one Eastern Ukraine.

The choice of oblasts was meant to reflect on the regional balance of Ukraine, diffusion of its HIV epidemic, and the perceived depth of penetration by the GFATM programmes. It resulted in the following categorisation of regions:

1) One of the regions that have the highest number of GF-supported projects, and high reported HIV prevalence;
2) One region that has few GF-supported projects and low (for Ukraine) reported HIV prevalence rates;
3) Two large populated regions with high HIV transmission potential that can have an impact on national morbidity and mortality, and high number of GF projects.

The following locations were chosen for interviews:

Region	Oblasts included	Location of sampling point/place of conducting interviews
Eastern	Donetsk, Lugansk, Kharkiv, Dnipropetrovsk, Zaporizhia oblasts	Dnipropetrovsk

Western	Chernivtsi, Ivano-Frankivsk, Khmelnytskyi, Lviv, Rivne, Ternopil, Luzk, Zakarpatia(capital Uzhgorod) oblasts	Ivano-Frankivsk
Southern	Autonomous Republic of Crimea (capital Symferopol), Kherson, Mykolayiv, Odesa	Mykolayiv
Central	Cherkasy, Chernigiv, Kyrovohrad, Poltava, Sumy, Vinnytsia, Zhytomyr, Kyiv oblast and the city of Kyiv	The capital Kyiv

Figure 3.1 Location of the sampling points

3.3.4 Purposeful sampling of respondents

Appropriate sampling represents one of the strategies to obtain reliable and verifiable data. Following Morse et al (2002,p. 18), the appropriate sample consists of participants "who best represent or have knowledge of the research topic". In this research, purposive sampling was used.

In Patton's view (1990), all types of sampling in qualitative research may be encompassed under the broad term of 'purposeful sampling'. He writes: "the logic and power of purposeful sampling lies in selecting information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal

about issues of central importance to the purpose of the research, thus the term purposeful sampling" (Patton 1990, p. 169). He describes 15 different strategies for purposefully selecting information-rich cases, among them: extreme or deviant case sampling; intensity sampling; maximum variation sampling; homogeneous samples; typical case sampling; stratified purposeful sampling; critical case sampling; snowball or chain sampling, and some others. Common to all these strategies is selecting information-rich cases that are selected purposefully to fit the study.

Respondents for purposive sampling are selected because of some characteristic. Patton (1990), Palys (2008), Sandelowski (1995), Morse (1991) and others provide numerous descriptions of cases of purposive sampling. Keeping in mind that 'research participants are not always created equal – one well-placed articulate informant will often advance your research far better than any randomly chosen sample of fifty' (Palys, 2008, p. 697), for the purpose of this research, I chose stakeholder purposive sampling, defined in the words of Palys as:

> Stakeholder Sampling: Particularly useful in the context of evaluation research and policy analysis, this strategy involves identifying who the major stakeholders are who are involved in designing, giving, receiving, or administering the program or service being evaluated, and who might otherwise be affected by it. (Palys 2008, p. 698)

The choice of stakeholder sampling was determined by the aims of the research and the need to focus on the policy making and policy implementation processes. In defining stakeholders, I adopted Pawson's (2006) definition, which regards stakeholders as key sources for eliciting programme theory and providing data on how the programme works.

A key determinant for inclusion into the research was respondents' prior or current involvement with GF programme implementation. Respondents were primarily national and regional government stakeholders, NGO service providers, and state health care service providers. At the *oblast* level, key informant interviews were conducted with local government officials and staff of GF Sub-Recipient NGOs. Representatives of international NGOs, bilateral agencies and other donor organisations working in Ukraine in the area of HIV/AIDS were also included. At the national and international level, independent experts were also included in the sample, to include people with expert knowledge of policy making in the HIV/AIDS

sphere in Ukraine. Additionally, more individuals with perceived knowledge and/or direct experience with the GF programmes that emerged during the interviews in oblasts, were invited to participate in interviews.

The respondents were also categorised into three geographical levels according to their location as: sub-national (oblast); national; and international. International respondents were located both inside and outside of Ukraine.

3.3.5 Participant recruitment

Prior to beginning the PhD research, the author has had more than 15 years of professional experience in the area of donor programmes in HIV/AIDS in Ukraine, as well as in a wider FSU region. The initial pool for recruitment was compiled on the basis of professional and personal networks acquired from author's professional experiences. In search of more participants, more individuals from among the oblast-based contacts were approached to determine their interest and availability for interviews. GF-funded oblast and NGO databases produced by PRs, mainly by International HIV/AIDS Alliance in Ukraine (Directory 2011), were consulted to obtain access to regional stakeholders, initially by e-mail and then by phone. Within NGOs, participants included both management and HIV service providers' level taken from different NGOs. A preliminary pool of contacts was established before field trips began. Snowballing techniques were used in *oblasts* to add further contacts to the initial pool. Individual interviews were scheduled upon arrival to the oblast according to local availability of respondents.

At the *oblast* level, when it was not initially possible to identify and make appointments with people only with GF experience, participants were sought from a HIV/AIDS sector background, also using snowballing. Because NGO participation in HIV services provision was among the key issues to be investigated, composition of the sample was purposely skewed to achieve sufficient representation of NGOs providing the services to generate sufficiently wide variety of data for analysis.

To recruit state sector participants, contact was made either through the oblast's health department with state health care specialists with known engagement

or expertise with GF-funded HIV prevention services, or individuals were approached directly. At the NGO level, the initial contact was to identify personnel with GF programme experience. At the national level, participants reflected a balance between different state agencies and levels of state servants including current or former CCM members.

In accordance with the aims of the study and the need to maintain a 'critical space', participant recruitment was skewed towards finding informants with a specific GF-related knowledge, who may not be typically included in donor-guided and PR-guided studies, and to give voice to a broader range of stakeholders on the ground. For this reason, because of perceived conflicts of interest, staffs employed at both PRs' Head offices in Kyiv, were excluded from the pool, and were not asked to identify the study participants, or to assist in the sampling of regions. The GF Sub-Recipients (SRs) in all three *oblasts* and nationally were recruited for interviews as informants possessing specific on-the-ground knowledge and experience.

3.4 Research limitations. Ethical and other issues considered before interviewing

An evaluation of the entire scope of GF programmes in Ukraine is outside the purview of this study. For my research, I interviewed respondents based in three out of the 24 *oblasts* of Ukraine, as well as in the capital Kyiv. The vast territory of Ukraine and the existing differences between the regions as to the perceived impact of the GF programmes preclude extrapolating data from several regions to the whole country. Rather, by analysing the roles, policies, relations and practices under the GF programmes in the three oblasts, I seek to raise more interest in the topic in the hope of generating a systemic look into the whole impact of GF-funded interventions on Ukraine's national HIV/AIDS response.

The midway point of the research coincided with the 2011-2012 reforms at the GF; after which many of the previously existing policies and documents were updated, and some were no longer available online. This complicated analysis of some documents as I consequently needed to find more secondary references to them.

Further limitations to this research lay in the lack of clearly identifiable HIV prevention services funded by GF, lack of services standards and the constantly evolving definitions of ‘service package’ and ‘client’ of services during the R1 and R6 implementation.

As Patton noted, the personal, conversational nature of interview situations highlights many of the basic ethical issues of any research method (Patton, 1990). Among these issues are: confidentiality, the need for informed consent, risk assessment, interviewer mental health issues, and some others.

1) Confidentiality –Asking people about their work and its impact on policy or the epidemic can make some people uncomfortable. They may feel they are viewed as beneficiaries receiving income from these programmes, or may not want to give negative comments because they feel this may harm the general perception of their work, or even their country. Because respondents may be sharing information that they can perceive as sensitive and having negative implications in their personal and professional lives if they are identified as sources, it is important to honestly assess and communicate to them how much confidentiality they can expect. The researcher also needs to consider how the confidentiality of individuals will be preserved when the data are analysed and reported. Related issues include who, in addition to the researcher, will have access to the data.

2) Informed consent - Most studies, for instance program evaluations, are covered by some kind of human subjects review process. This will usually require that respondents sign an informed consent form agreeing to participate, after being informed of potential risks and/or benefits. In pre-interview communication, participants were assured that every effort would be made to store data safely, and that the author would not collect any personal or other information that might indirectly link a respondent with a particular response.

3) Risk assessment - It is important to consider all potential risks and include them in the informed consent process. Even though "just talking" may seem inherently harmless, people who participate in open-ended interviews may experience psychological stress, or pressure by peers or staff who believe that the participant

may say unflattering things about them or their organisation to the interviewer. To mitigate the risk of potential peer pressure, every effort was made to space out the meetings and locations and make independent arrangements with each study participant. For the same reason, it was decided not to have focus group discussions, in order to generate more candid responses and avoid stakeholders in the same location being aware of what others were saying. This meant planning for additional time during each regional trip. In terms of personal risks, there were no political upheavals or unrest at the time of the interviews (2011-2012).

4) Mental health of the interviewer - Interviewing can be an intense interpersonal experience. In the same way as participants may experience psychological stress from disclosing sensitive information or talking about unpleasant situations, interviewers may be overwhelmed by the sensitive nature of what they see or hear, especially in the field, when they are away from home and family. Although the author did not personally experience any psychological harm during the interviews, there was general fatigue after intense personal interactions. The author mitigated psychological problems preventatively by allowing extra time when on location for physical activities such as exercise and taking strolls, to the place of interviews and back to the hotel, visiting churches and local markets. This was a pleasant, stress-relieving experience, also enabling the author to observe economic and social life and various human interactions, which was useful to gain insights into the local context of life in the studied regions.

Despite the ethical issues identified above that were associated with this study, there were potential benefits of the research believed to outweigh potential harms because:

- Even though some participants may feel sensitive about being asked about some aspects of their professional activities, their responses may contain important information relevant to the subject of research that has not been provided before. In some cases, respondents reported or appeared to experience a degree of relief in discussing issues freely in a safe environment.

- The GF is a global tool for combating HIV/AIDS, providing funding in many cases when local resources are insufficient. Qualitative research draws from participants' experiences directly and thus may be a better instrument to identify challenges and allow people with a more critical outlook to share their views.

3.5 Field work

As noted by Miles and Huberman (1994, pp. 55-56), "data collection is inescapably a selective process" in which "you cannot and do not 'get it all' even though you might think you can". Selectivity was practiced at all stages of data collection, and included a careful selection of study participants.

3.5.1 Conducting the interviews

Following a sampling plan, a core group of contacts was identified in Kyiv and three regions suggested for visits. Contact was made with the initial core group by e-mail, while still in Edinburgh. After the clearance from the Ethics Panel was received, pilot interviews were conducted in Kyiv in October 2011. The pilot phase generated a few corrections to the Interview Guide, and after consultations with a supervisory team, I proceeded to the first regional trip.

Field trips and Kyiv-based interviews were conducted between October 2011 and September 2012. A total of 52 individuals were invited to participate in the study, and 50 consented. The interview process included the following:

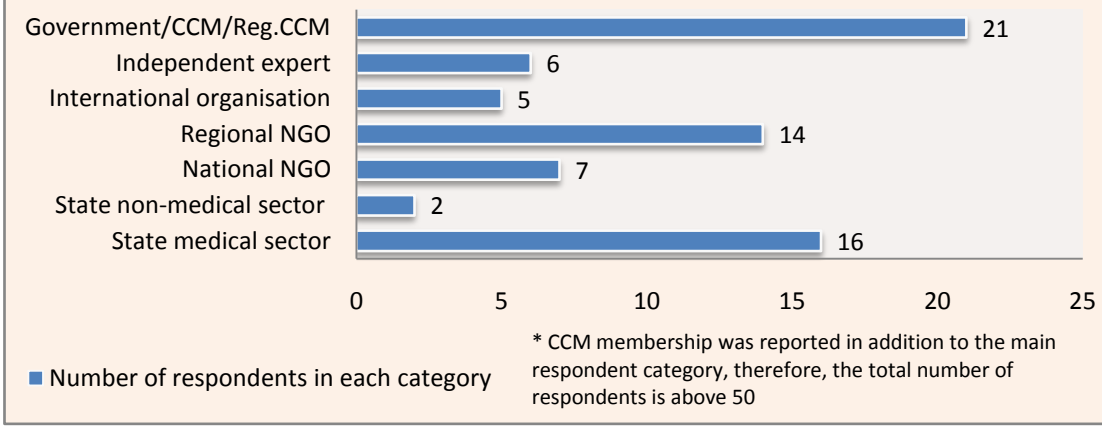
- In advance of the interview, I sent by an e-mail, or post, the information sheet (Appendix G) and let the potential respondent know more about the research. If a participant was identified during the field visit, information sheet was given at the meeting and time provided for the participant to read it.
- At the meeting, in addition to information sheet, I presented some personal and background information, and explained why the opinion of the respondent was needed and how important it was to obtain the data for research purposes. Information about collection of data, storage, anonymity

and confidentiality was explained at this stage. Any questions on the side of the respondent were asked at this point.

- Then the interviewee was asked whether he/she would like to continue, and if yes, if he/she would like to sign a consent form. Decision on whether to participate in the interview immediately or at a later date, was made at this point. Written informed consent forms were collected of all 50 participants, currently on file with the author.
- The interview would then commence. When necessary, breaks were made.

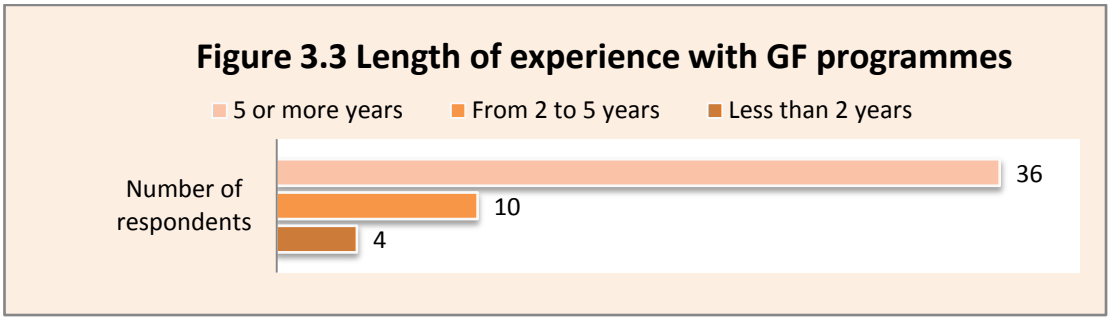
All 50 respondents had knowledge or experience of GF work in Ukraine and/or internationally and represented a diverse background. Ten were CCM members at the time of interviewing or within the five preceding years, and eight were members of regional coordinating councils (see below the distribution of respondents by their self-identification):

Figure 3.2 Self-identification of participants*

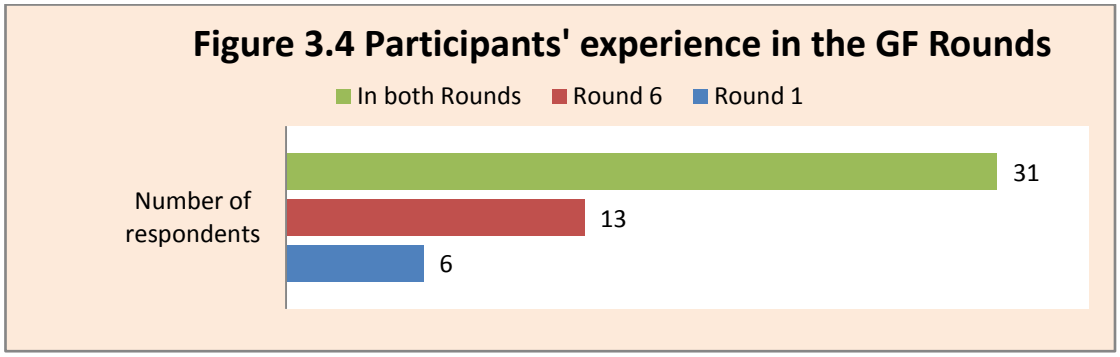


Overwhelming majority of the participants had five or more years of experience with GF programmes (see Fig. 3.3):

Figure 3.3 Length of experience with GF programmes



Most participants had experience in both GF R1 and R6:



Interviews with 27 regional respondents were conducted by researcher in either Russian or Ukrainian, based on the participant's choice. The 23 national and international interviewees spoke in Ukrainian, Russian or English.

Interviews took place wherever it was convenient for the interviewee and private enough to preserve confidentiality. Eleven interviews were conducted in health care facilities, including oblast AIDS centres, drug clinics, sexually transmitted infections clinics, other regional health institutions. Interviews with five government officials were conducted in government buildings. Another eleven interviews were held with heads of regional NGOs at offices of regional NGOs or needle exchange program facilities. The remaining thirty interviews were conducted in places convenient for the participants. Two interviews with international participants were conducted by Skype. Participants were receiving no reward, per diem, or other financial compensation. Interviews lasted between 20 minutes and two hours, with the average interview duration of 65 minutes.

Total of 27 interviews were conducted in *oblasts,* with the following distribution across the regions:

- 10 interviews were conducted in Ivano-Frankivsk,
- 9 interviews conducted in Mykolayiv, and
- 8 interviews conducted in Dniepropetrovsk.

3.5.2 Recording and transcription

Most of the interviews were conducted in Russian or Ukrainian, while several others were done in English. It was decided to transcribe interviews in the original

languages as they were conducted. The author is fully fluent in all the languages used in the interviews. One of the reasons to keep the original languages was the need to stay closer to the original meanings and original text, and generate the initial codes, as they were implied in the original meaning by the participant, before categorising them into themes. The author is aware of communication difficulties in Ukraine arising from translation. Some previous foreign researchers conducting interviews in Ukraine noted that simultaneous translation during the interview was "creating a potential for communication difficulties" (APMG 2009, p. 13), even if using professional translators knowledgeable in the subject matter. Keeping interviews in the original was also viewed as an additional layer of preserving confidentiality and anonymity of the informants.

This research uses transcripts of recorded interviews as text data. Transcribing started in January 2012. All interviews were transcribed in full, except for repetitions, and irrelevant personal narratives. With most interviews transcribed before summer 2012, final transcription ended in December 2012.

3.5.3 Safeguarding the data

In order to ensure confidentiality and safeguard identifying information, participants' name, age, and demographic information were not reported in the findings.

Self-identification was used to allow participants to categorise themselves for the study. Only general work-related categories were offered to differentiate between various stakeholders, and with not much detail to allow identifying their positions or organisation/s. Regional or sector identities are not disclosed in quotations in the text of the thesis.

Given the nature of some of the respondent's roles, every effort was made to fully anonymise their responses from others working in the field. For example, with the government stakeholders, the total number of government stakeholders interviewed in all sub-regions could be revealed, without providing the list of government departments or organisations to which they belong in a particular sub-region. This ensured the anonymity of individual subjects interviewed without losing the general characteristics necessary to distinguish them for research purposes.

The same principle applied to NGO staff/service providers. This thesis does not supply the list of NGOs whose staff were interviewed, and reports their responses by numbers only. This ensures their anonymity and that their names cannot be linked to the name of their NGOs that operate in the region sampled.

All identifying information present in consent forms was kept separate from the audio recordings and transcriptions and no tracing identity is possible based on the data stored by the author. Numerical codes were assigned to each transcript and in the thesis participants are quoted by these numbers only.

Regarding the technical side of data collection and storage, all due precautions outlined in the Ethical Panel approval, were followed. Each interview was recorded, and an audio file stored only on the researcher's personal, password-protected laptop. This computer was not connected to any computer network. Backup was on a external device (floppy drive), that is also password protected.

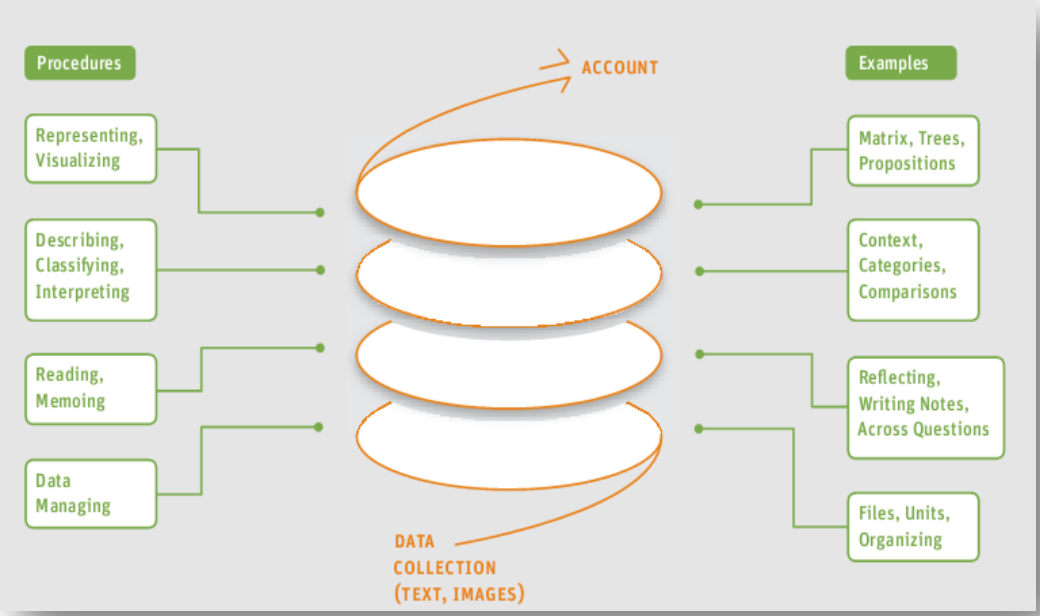
All files, field notes, analytical memos, and other study materials have been stored in a safe, locked location at researcher's home, and will remain within such restraints for the time period outlined in Ethical Panel recommendations and ethics regulations. After this time, all paper and digital materials will be destroyed.

3.6 Data analysis

3.6.1 Following Creswell's data analysis stages

All the transcribed data was in textual form, which suggested a choice of analytical tools for analysis. As Dey (1993, p. 6) notes, qualitative researchers "learn by doing". Qualitative analysis is "mainly to help us learn" (Miles and Huberman 1994, p.10). While qualitative research may require reliance on three "I's" – "insight, intuition, and impression" (Dey 1995, p. 78), Creswell (2007) suggests that the data analysis goes by a spiral:

Figure 3.5 Cresswell's "Spiral of analysis"



According to Creswell's spiral, the analysis begins with the gathering of data, and moves into data management – organization of files and records, writing memos, and reading data, then reflecting, then on to describing, classifying, and interpreting, categorizing, and comparing, and finally, representing and visualizing the data.

What Cresswell's spiral represents visually, Miles and Huberman (1994, pp. 11-12) define verbally by outlining three major stages of data analysis:

1. Data reduction (simplifying complex data by, for example, extracting recurring themes via coding);
2. Data display (e.g., matrices, charts, graphs, etc.)
3. Drawing conclusions and verifying them as a means of testing the validity of findings.

The research followed these three stages of data analysis.

3.6.2 Coding. Categories. Content analysis

Coding, also called indexing, is used to organising the data and reducing it to manageable proportions. The SAGE Encyclopaedia defines coding in qualitative research as "the process of generating ideas and concepts from raw data such as

interview transcripts, field notes, archival materials, reports, newspaper articles, and art" (Given 2008, p. 85).

Coding is at a basic level, any way of categorizing and sorting data for the purposes of analysis. Coding involves the breaking down of research data into units which are then grouped according to their characteristics. A researcher applies meaning to raw data by assigning key words or phrases to sub-units of data. These key words then act as signposts to themes within the data. The process of coding is well-described in a number of qualitative methods manuals, including Dey(1993); Lofland and Lofland (1995); Miles and Huberman (1994).

In doing coding, a researcher is aware of its perceived subjectivity. It requires a researcher to walk around in the life of the participant and to try to interpret what is being said in a way that is congruent with what the participant means (Robertson, 2008). It is important to maintain as much 'trust-worthiness' as possible. The researcher needs to keep an open mind and avoid pre-conceptions, interpreting the data, while remaining true to what the participant said and how they said it.

The steps of data coding outlined by (Corbin and Strauss 1990) have appeal to those researchers and research funders who desire scientific rigour. If research reports contain accounts of indexing and coding schemes with illustrative examples for each code, some readers may be more willing to believe that a logical and systematic approach to analysis has been taken.

However, Coffey et al. (1996) expressed doubts about the narrow, reductionist character of analytic strategy that is imposed when coding is used as a first step to theory generation. Their concerns are heightened if analysis is conducted with computer-assisted qualitative data analysis as this encourages standardised, mechanistic procedures that fragment and de-contextualise data into discrete sections.

Similarly, Krippendorf (2013) wrote about the limitations of computer text analysis:

> [C]ontent analysts must look outside the physicality of texts – for example, to how people other than the analysis use these texts, what the texts tell them, the conceptions and actions the texts encourage. ... [C]omputer text analysis

> cannot point to anything outside of what it processes. Computers have no environment of their own making: they operate in the contexts of their users' worlds without understanding those contexts. (Krippendorff 2013, p. 29)

Seale (1999) sees indexing as a preceding stage to coding. He argues that indexing is an attempt to fix meaning on to the world, and that while this process excludes other viewpoints, this exclusivity is required in order to persuade audiences of the validity of the research. An issue remains, however, if coding fixes meanings too prematurely during the process of analysis thereby preventing the analyst from seeing beyond his or her initial ideas. Seale argues that indexing should be seen as an early stage within the process of coding and represents an initial signposting of data rather than representing final theories.

The first stage of data analysis typically involves familiarisation with the data through a series of re-readings in order to obtain a general sense of their meaning. The familiarization (or data immersion) is usually carried out on a small section of the full data set such as one or two interview transcripts. At this point the analyst may be writing notes on the types of topics contained within the data. A thematic framework is then developed according to the key research objectives and emergent themes, with similar topics clustered together. Sections of data are then indexed according to the framework, with coding categories refined appropriately in response to the data. The aim at this stage is to generate sections of data with multiple codes and for the process to be as inclusive as possible, codes being added to reflect all kinds of nuances in the data rather than trying to fit the data into a few core codes.

Categories

> Coding is looking for key words, phrases and ideas that arise directly from the data. You are looking for similarities and consistencies in what the participants say. You are also looking for differences and inconsistencies, contradictions. You are looking to develop categories and sub-categories.
>
> Ian Robertson (2008)

Categories can be described as high-level codes – concepts that allow sub-codes with common properties to be grouped. Category development can be done either inductively or deductively (Given 2008, p. 71). To generate categories inductively, the researcher approaches data analysis without a preset list of categories

and analyses the data to identify analytic units that conceptually match the phenomenon portrayed in the data set. When categories are generated deductively, they emerge not from the data but rather from prior studies, relevant literature, research questions, and the researcher's own experience with and knowledge of the phenomenon. A risk to using the deductive approach is that the categories generated from other sources will not be relevant or accurately reflect the qualitative data set at hand. Because data was generated from both interviews and background literature and reports, in making up categories, the synthesis of both sources was done.

All interviews were transcribed verbatim and analysed using thematic content analysis. The steps consisted of: categorising the information from all the interviews and finally, theoretical coding in which open codes and categories were compared to generate an analytic schema and to interpret the findings.

The coding process had two stages:

1) *Early coding stage.* I did open coding using the participants' own words and phrases without preconceived notions or classification, and in the original languages of transcription (Russian, Ukrainian, English), following the coding process guidelines described by Ian Robertson (Robertson, 2008). The first matrix contained codes done in original During this stage of coding, I coded and marked all interviews, and browsed through the data to see what was there, and what patterns were emerging from the data. I recorded those with margin notes - using the high-lighter, marking the key words. Documents were formatted with a wide margin to enable writing. Sticky notes were used to mark the codes on the pages. Thoughts and ideas were recorded in a reflective journal.

At this stage, some preliminary, 'raw' initial categories - proto-codes –emerged, and they were incorporated into an initial, "raw" matrix. This manually-drawn matrix was used to demonstrate how codes/emerging themes/categories can be represented visually. This first matrix accomplished the following:

- generated an initial list of items from the data set that have a reoccurring pattern;

- assembled all emerging themes in one chart;
- grouped them into broader categories;
- established links between categories – without suggesting hierarchy or predominant meaning.

2) *Advanced coding stage.* Before commencing the second stage -- refining, expanding and/or rejecting initial categories –the interval of two months was made. The goal of the interval was to 'cool down' and abstract from initial categories, while translating the proto-codes into English. This proved a useful strategy as, on a fresher look, some categories appeared more "saturated," as defined by Merriam (2009), while others with no or limited significance were eliminated.

At this stage, descriptive proto-codes were beginning to transform into more abstract analytical categories as re-coding progressed. Relations between categories emerged, including sub-categories – belonging to the same semantic category but naming a less general phenomenon with similar properties to a wider category.

Following this, a second matrix was constructed, with all themes translated into English and grouped into vertical columns by categories and sub-categories. The design and construction of the second matrix had clear data reduction implications that included, according to Saldana's (2009) 'think display' principle, the following:

- Looking for weaved-condensed meanings-codes;
- Creating a visualisation of actual codes;
- Establishing key emerging themes.

Based on the themes that emerged during the advanced coding stage, several major themes were further analysed using content analysis. Computer analysis software was not used in this study. Since the objective of the research was not aimed to produce generalisable or universally applicable conclusions, the author was not looking for quantifiable (most frequently used) words, neither had she aimed to prioritise among most frequently and less frequently mentioned ideas or concepts. Instead, my analysis was aimed to capture as many as possible accounts within the chosen thematic categories since the ability of this study to produce broad accounts of various aspects of GF implementation was perceived as a most valuable

contribution. In constructing the meanings, following were taken into account: (a) the general thematic framework of the Interview Guide, and (b) emerging codes generated after the advanced coding stage. In doing this, it was assumed that the initial Interview Guide already provided for a certain level of saturation. Added by a purposely selected participants and their mature level of informedness, this was also supposed to add to the saturation of initial information at the point of collection. After the emerged themes were obtained from coding, the saturation of meanings further increased. Then a minimum threshold was set of the use of unit in context to be included into analysis: being the minimum of two uses of the sub-theme mentioned by two different participants.

From the themes that emerged after the advanced coding stage, several major themes were further analysed using content analysis to develop the results described in the findings chapters, and synthesised with document and literature analysis. They included:

- PRs' roles and relationships with other actors in GF programmes;
- Linkage of GF-funded HIV services with state health care;
- Focus of GF-funded HIV prevention services;
- Target setting systems and practices for HIV prevention services;
- Coverage of clients by HIV services;
- Data collection systems used by PRs to demonstrate service delivery;
- CCM perceived roles and effectiveness;
- CCM decision making practices.

The analysis done during the last –'post-coding' stage- refined coding by doing 'coding-marking' that was about seeking instances of context use of the selected themes and sub-themes. At this stage, all the individual interview transcripts were re-read again, and textual instances were marked as they appeared to be linked to the emerged themes. This was meant to generate textual evidence that is used widely in findings chapters as direct participants' quotes. This process was mostly manual - bigger quotes were put in the computer, while smaller quotes were written in a matrix at specially allocated spaces.

CHAPTER 4: THE SPECIFICITY OF NGO DELIVERY IN UKRAINE'S HEALTH CARE CONTEXT. TARGET SETTING PRACTICES FOR HIV PREVENTION. PR PERCEIVED ROLES

> There is a big contradiction that large funds are concentrated with NGO but government is responsible for healthcare. The risk is that money will not be spent for the purpose it needs to be spent, because GF priorities in funding [HIV] prevention may not coincide with state policy or even run counter to it.
>
> (Anonymous respondent, Ukraine)

4.1 Challenges of NGO delivery in the health care context

As argued in Chapter 2, NGO management of GF programmes posed challenges in Ukraine. First, there was never a programme of such scope implemented before. Second, following the transfer of the R1 grant to the Alliance, there was little willingness on the side of the government to see the GF-supported programme as part of the national HIV/AIDS response (Drew 2005a). Lack of national ownership with minimal government commitment and support carried a risk of the GF programme being seen as a 'stand-alone' project (OIG2008). Other challenges included sustainability concerns over the perceived role of the GF as the largest external funder for HIV prevention in Ukraine. In the absence of government involvement and dwindling support from other development partners, should GF funding come to an end, no other funding source was available (OIG 2008).

Yet, challenges of a different kind, associated with the nature of the programme delivery, appear relatively less studied. In line with ethnographic inquiry approach, Chapters 4 and 5 that follow are bringing forward the evidence that emerged from my analysis, concerning the specificity of NGO service delivery in GF-funded settings in Ukraine. The focus is on HIV prevention services as delivered by PRs, chosen as the focus area for this research. Here I argue that the way how the GF's own systems and principles, such as performance-based funding and country ownership, applied in Ukraine, as well as the GF's focus on NGOs to deliver

implement its programmes, had a fundamental impact on channelling of the GF funding, organisation of HIV services, target setting, and other practices at the country level and in *oblasts*. Material presented in the following chapters is a synthesis of the document and interview data analysis, with interview data as the primary evidence.

4.1.1 The nature of health-care delivery in Ukraine: state as the only provider of health services

When the R1 proposal was prepared, the major focus of the grant - 70% - was to provide treatment, care and support for HIV/AIDS patients (Brusati2003). The focus of care was the provision of ARV therapy (APMG 2009, p. 6) in which state health institutions and state-paid health-care workers were seen as the main providers of services, with NGOs assisting in referral services, as well as in care and support. The prevention component constituted a small part of the original R1 grant, while the World Bank project, also launched in 2004, had an HIV prevention component for high-risk groups. The Bank's project was not implemented, however. The delivery of services by NGOs was among the biggest risk factors for the Bank project, as noted in its closure report (Bank 2009).

In contrast with the Bank, an anticipated outcome for the GF programme was robust and effective delivery of HIV services by NGOs. This expectation stemmed from the GF's perception of a special role of civil society organizations as linked to or representing the vulnerable communities and thus having better access to them.

However, access alone was only part of a solution. With a key focus of the R1 programme on the provision of ARV treatment, ARV procurement was not the only field in which the "Alliance did not have experience" (Drew 2005a, p. 3). The delivery of other health services by an INGO presented a problem.

Ukraine's AIDS health care being a vertical, separate health-care system, the public sector was the only one "to provide services needed to the fullest extent" (UNAIDS 2007, p. 39). Under Ukrainian law, NGOs cannot directly engage in the provision of medical services, even less acceptable are international NGOs. The lack of a legal framework for NGOs was pressing, in particular, for such GF-funded

activities as HIV screening tests and needle exchange provided by NGOs, which fell under strict laws on medical waste utilisation, a legacy of Semashko *SanEpid* control[61]. Eight years after the start of GF programmes, a USAID-funded report noted that for NGOs to provide HIV counselling and testing services: "licensing and accreditation system has not actually been developed or implemented" (Judice et al. 2011, p. 44). The lack of legal framework carried the risk that many NGO-based health services would have to be provided *ad hoc*[62] and, as such, may not be recognised by the state.

The other issue was a famous GF 'medicines without doctors' dilemma that did not allow its programmes to pay salaries to health workers (Ooms et al. 2007). According to this, no health-care institutions could be paid by GF to administer ARV, even if a country received them from the GF. Administering ARV drugs is a complex and time-consuming process that draws resources from the general health-care system into narrower channels of operation — a problem which is not unique to Ukraine.

In Ukraine, services of licensed health workers were needed in particular for: (1) blood screening for antibodies to HIV; (2) administration of ART; (3) administration of methadone. With the government as an implementer, the services were to be delivered by state health-care workers. With a transfer of GF money to an INGO, the perceived division of roles between state health care and NGOs ceased to exist. Having an NGO acting as implementer for what was designed as a typically health service–oriented programme, introduced role distortions into the provision of health care. The nature of the services to be delivered immediately put a PR in an awkward position.

In general, participants viewed the state as the main provider of health services and perceived NGOs as being responsible for care and support:

[61]Environmental protection of waste control legislation in Ukraine, while not adequately enforced, has remained in existence from the Soviet times, a responsibility split among SanEpid and state environmental protection services.

[62] With a strict regulatory framework in existence, responsibility for syringe utilisation was passed on by PRs to sub-recipient NGOs. Regional NGOs were expected to work on the basis of "notifying the regional authorities about the beginning of harm reduction programmes in their region" and "clarifying the conditions for collection, transportation, storage and utilization of syringes with regional SanEpid branch" (EHRN/WHO Europe/GTZ/AFEW 2008, p. 13).

> The state has [the] potential to deal with HIV. (006: 11-112)

> We do not want to take over the roles that the state should fulfil. For example, treatment. Or prevention. But we can do care and support...Non-medical care. But we cannot substitute the state. (036: 158-180)

In GF programmes, the role division between NGOs and state was largely perceived by participants as unclear and challenging:

> There is no clear division of roles…What is state doing? What are NGOs doing?... We need to define this division clearly... and then we won't interfere in their work and they won't interfere in ours. (020: 352-358)

The NGOs' role as GF implementers was also viewed as contradictory and atypical:

> There is a discrepancy in that the government is responsible for prevention, but the actual implementation rests with NGOs. So this external funding is managed by an external NGO working in Ukraine – an organisation that does not have overall stewardship for this arguably a public health service... There is a contradiction here... given that the principal recipient of those funds is a non-government organisation, which then channels the money to non-governmental organisations to do the work. (049: 60-68)

The duality of service delivery and advocacy roles of NGOs

The dual role of NGOs as implementers of GF programmes and civil society advocates has been widely discussed.

On the one side, Harmer et al. (2012) argue that an important outcome of the GF HIV/AIDS grants has been the increased professionalization of CSOs[63] through adopting adequate project management, accounting, grant and financial management, and monitoring and evaluation practices, etc.; which has also been reported by Kapilashrami and O'Brien (2012). This is believed to have led to an increase in government officials' respect for CSOs, helped to build trust, and challenged government stereotypes of CSO organisational capacity.

Donor publications in Ukraine appear more concerned about the duality of NGOs roles as implementers and advocates, mentioning posed risks to NGOs becoming less independent, and to programmes not being sustainable. This was mentioned by UNAIDS in relation to *Merezha* becoming a GF co-PR in R6:

[63] As was mentioned before, the terms 'civil society organisations' (CSOs) and 'nongovernmental organisations' (NGOs) are used interchangeably in this thesis in relation to Ukraine

> As organizations such as the Network focus on implementation of large programmes and services as the PR for Global Fund grants, they risk undermining their role as effective and independent advocates on behalf of civil society. The systematic lack of Government involvement and support for programmes ...implemented by NGOs also represents a serious risk to their long-term sustainability. (UNAIDS 2009, p. 31)

Participants similarly noted the challenges that NGO implementation posed to sustainability:

> GF needs to interact more with government-funded programmes, not just NGOs. Because when the GF collaborates with the state and it leaves, the state feels responsible for the [GF] money and for the money it put in, and can pick up where the GF left off. When NGOs are receiving [GF money], only the NGO network grows. Because NGOs are on external funding, they are a high risk in terms of continuing activities if the funding ends. (027: 277-286)

> The state is used to NGOs doing prevention. But if [GF] funding stops, the state is not ready to support this work. It is only loyal to NGOs because they receive grants. If the state has to fund this, it won't..It has different priorities. (036: 204-231)

Other perceived roles of PRs NGOs not directly related to health-care delivery are described later in this chapter.

4.1.2 Channelling GF money: divide and rule

Drew (2005a) outlined two ways by which the Alliance channelled GF funds for service delivery:

> 1) By providing direct grants to NGOs and government departments, done by competitive tendering for new partners and direct granting to existing partners; and
> 2) By indirect granting (sub-grants) to local NGOs through other national NGO recipients.

In R1, Drew noticed that different granting procedures were applied to different NGO categories: while grants to new partners were issued through a competitive tendering process, existing partners and partners with "unique capacities" were issued direct contracts. Among Drew's concerns regarding the

tendering process were inadequate time for responses and the perception that some tenders "were tailored to specific organizations" (Drew 2005a, pp. 5-6).

In the later stage of GF implementation, divisions and classifications between different Sub-Recipients (SRs) became even more pronounced, contributing to a growing rift among them. The Alliance staff manual on grant-making defines all SRs as 'implementing partners' (IPs)[64], and classifies them according to the amounts received (below 50,000 Euros; between 50,000 and 300,000 Euros; and above 300,000 Euros); by scale of activities (local, national and intermediary IPs); and by status. The 'status' classification reveals PRs' high degree of discretion. It falls into several categories, taking into account whether IPs are *new* or *existing partners* of the Alliance or whether they *possess a unique capacity* to implement HIV/AIDS programmatic activities in Ukraine. While the first two categories can receive money under an open call for proposals, IPs with a unique capacity follow a closed call for proposals procedure and receive money as the only participant of such a closed call. Among the criteria for being selected as a 'unique IP' are: "having exclusive capacity and experience in implementing the supported programmatic activity, *which is not possessed by other organisations*; ... being *the only visible IP with an outstanding record in the specific area* of programmatic activity; as *a favoured implementer* of the specific programmatic activities" (Alliance 2007, p. 6) The vagueness of the classifications suggests a high level of PR discretion in making decisions about awarding grants, while allowing some IPs to bypass the competition suggests the existence of double standards. Sadly, it also manifests that the perceived strength of NGOs PRs having close links with other NGOs in Ukraine did not appear in practice. Instead, being put in charge of GF funding allowed PRs to become arbiters in money matters over other NGOs, which strongly affected the nature of the relationships between them. As Drew noted, "where financial relationships exist, interactions may be financially motivated or interpreted as such" (Drew 2005a, pp. 14-15). Another study on the GF in Ukraine noted in regard to the distribution of GF funding to SRs, that "personal connections with Principal Recipient staff are believed to increase the chance of receiving a grant" (Semigina et al. 2008, p. 6). In the context of the nascent

[64] "Implementing partners are the Non-Governmental or Governmental Non-Profit Organisations, which implement certain programmes or projects funded by Alliance Ukraine" (Alliance 2007, p.3).

civil society in Ukraine, the power and control that PR NGOs gained from being in charge of massive funding was a threat to the still fragile NGO partnerships.

Participants found grant procedures difficult and dependent on personal connections:

> Alliance has established priorities, and pre-determined organisations that will get funding. The grant competitions are so difficult that without special training it's impossible to even fill in the application. As a result, only 'known' NGOs can win. (012:454)

> NGO heads began entering into closer relations with Alliance managers to achieve preferential treatment for their NGOs. (046: 192-194)

PR discretion was also manifested in the way how they determined the length of NGO contracts. While for some NGOs, contracts ran for one year, eight months or nine months (Alliance. n.d.1.), others were just renewed. The renewal was at the discretion of the relevant PR staff, based on the past performance of the existing IP, rating, the availability of funds, and on whether the renewal was needed (Alliance 2007). The short length of most NGO contracts was noted by a study on NEPs[65] in Ukraine, which noted that "lack of sustained funding" was one of the reasons the programmes did not reach high coverage in 12 months, which was the length of funding contracts (Burrows 2006, p. 875).

The lack of a unified approach to funding and varied PR standards as applied to the SRs had important implications for access to services in *oblasts*, sustainability of services, as well as for relations between NGOs, and NGOs relations with the state.

One especially problematic outcome of NGO-state relationships appeared as a direct consequence of PR sub-contracting systems. Its essence lay in the need to engage state health workers in service delivery.

4.1.3 Problematic sub-contracting: hiring state health workers. 'Quasi' NGOs

With the government as a whole sidelined by the money transfer to an INGO in R1, the need to engage with state health institutions to deliver health services was

[65]NEP – Needle Exchange Programme.

imminent. To implement what was designed as a health service-oriented programme, the PR needed to develop a working mechanism to engage with state healthcare system. The decision was for a PR to provide funding to local NGOs, which would then hire licensed health workers from state health institutions in their regions. A system was created that "recruited doctors (infectious disease doctors, narcologists, dermato-venereologists[66] and gynaecologists) and nurses to work in mobile clinics and in other settings fully or partly operated by NGOs" (APMG 2009, p. 16). Says a participant:

> As grant distributors, they [PRs] could maybe do a lot. But in health services, their capacity was not great because they had to hire the health-care staff in order to implement these [GF] grants. They paid for specific work, for a specific task. (023: 143-147)

The involvement of medical staff was perceived as more of a necessity, and as a temporary solution for NGOs to run HIV services outside of health facilities:

> The problem was that high-risk groups at that time did not want to go to government facilities…The eventual compromise was that doctors from AIDS centres would go to NGOs. This was not a bad solution. You were giving money to state officials to do their job – this is what was happening. (045: 505-510)

> We were told to organise the utilisation of syringes. It is hard work and should not be given to NGOs. There are many regulations. We were told to find a smart solution to this ourselves... So we signed a formal agreement with a local medical facility that they would supposedly take our syringes to use. For this, we employed their head doctor in our NGO. (046: 230-240)

This decision was problematic because, in participants' view:

> The GF should not finance support for governmental institutions through NGOs. We have anti-corruption legislation. If there is budget line for an NGO to finance a state institution, and state employees receive something from this NGO, this knowingly cannot be done. Because state officials are not allowed to receive payments other than official salaries or scientific honoraria. [B]y recognising this expense, they [GF] expose implementers to the risk of being accused of corrupting state officials. (044: 430-436)

[66]Dermatology and venereal diseases doctors operate as part of 'STD – sexually transmitted diseases' dispensaries – that constitute a separate, vertical part of the healthcare (the outline of the Ukrainian health system is provided in Appendix C).

'Quasi' NGOs

Hiring state health-care workers through NGOs continued and proliferated and brought about an even more problematic development. Participants reported that NGOs were beginning to be created by doctors themselves, and in particular, by head doctors of regional AIDS centres and drug clinics: "NGOs were created by people who worked [in AIDS centres] and they controlled these organisations. It was like, the head doctor of an AIDS centre or his deputy registers an NGO in his name or that of a family member, and this organisation then works as an NGO" (012:202-207)

Among the motives for doctors opening their own NGOs was receiving additional pay for administering ART and other medical services, to serve the needs of GF programmes. As participants described:

> Payoffs to doctors were used to push through the policies necessary to implement GF programmes. (046: 353-355)
>
> One head of [name] AIDS centre in conference said openly: 'We formed an NGO to get more money. That way we could get paid a supplement to our ordinary salaries.' (045: 505-514)

Participants used the term 'quasi NGOs' to describe 'doctors' NGOs', suggesting that the way they functioned was artificial and not as a real NGO:

> Why do you need a quasi NGO? Because in this way you can show a quasi-collaboration with the state and report on a partnership, without any hassle. (047: 393-395)
>
> Practically all decisions are agreed on by the head doctor. There is no independent NGO position. NGOs may also be run by these doctors' patients. (012: 205)

Participants suggested that top-ups to state AIDS workers created tensions and benefited individual medics rather than the health system:

> The problem is quite difficult, because if you give salaries that are too high, it's also bad. Because other doctors in the same building are getting much less and are very angry about this…It creates tensions and it creates very complicated situations. (050: 281-290)

> AIDS centres forming NGOs was talked about quite a lot. But this seemed to benefit individual medics the most. It really did not seem to be strengthening government institutions. (049: 238-240)

These findings resonate with some recent publications on the GF in Ukraine. Spicer et al. (2011b, p.22) noted that "government staff had established NGOs to apply for Global Fund and other donor grants, enabling individuals to supplement their salaries."

Regarding the areas in which doctors' NGOs proliferated, participants believed they were most common in 'priority regions' because:

> PRs wanted to work with priority regions because they had established relations with AIDS centres' doctors. (015:133-38)

As to the number of 'quasi' NGOs, participants believed that they represent from "one third of all NGOs [funded by the GF]" (012: 467) to "half of all NGOs" (014: 265), or as being opened in "in almost every AIDS centre" (015: 329).

Zhukova (2013) argues that international organisations use AIDS NGOs in Ukraine as *"tools for opening pharmaceutical markets and accessing clientele groups,…*increasingly pharmaceuticalizing the population, and blurring the lines between activism and patienthood" (Zhukova 2013, pp. 129-130)[emphasis added]. In this sense, 'quasi' doctors' NGOs represent an ideal instrument for accessing Ukraine's markets and PLWHA, and explain why the involvement of medics in the organisations of their patients whom they were supposed to cure and protect, despite the gross ethical dilemma it entailed, was tolerated and supported by the GF.

Participants viewed 'quasi' NGOs as detrimental to Ukraine's 'Third sector':

> Quasi NGOs may be necessary when the Third sector is not developed in a country. But we had a developed third sector, and there were strong organisations, almost none of which remained afloat, because they were pushed out by these AIDS centre-based organisations. These quasi NGO are harmful…A critical mass of fictitious NGOs was created, and when the critical mass of quasi NGO gets too big, the process is irreversible. It kills the real NGOs. Now there is no strong third sector any more. It does not exist. (047: 437-461)

Some participants reflected that, by paying doctors, NGOs were not doing advocacy, but buying loyalty from the state:

> *Paying doctors through NGOs… this can be seen as a sort of hand-out to the state…This system of handouts received wider recognition* [in GF programmes]. Instead of lobbying the state to take on the functions that it would – and should – normally perform, we were financing local health administrations or doctors. This put the state in a 'dependant' position. This was faulty in every instance, because when you go to a CCM meeting, and there are people who do not receive money from you, but they see how others get it almost for free and for doing nothing – i.e. for their regular work – they begin demanding the same thing from you. *By giving such handouts we were buying loyalty from the state.*(046: 240-257) [emphasis added]

Overall, participants reported active and frequent involvement of state officials in receiving payments through GF-funded NGOs:

> NGOs pay off government bureaucrats. They won't survive if they don't.(043:90-92)

> [There is] active collaboration with the state. State officials get invited to meetings, to participate in projects as consultants. There is interest on the side of the state, and it is possibly also financial. (026: 200-203)

4.1.4 The GF programme engagement with HIV care continuum: a 'broken link'

Chapter 2 describes the HIV/AIDS health-care entitlements within the HIV care continuum in Ukraine. The GF-supported programmes "contributed to the implementation of the majority of tasks included in the Ukrainian National HIV/AIDS Prevention, Treatment and Support Program" (OIG 2012, p. 3) and were thus expected to contribute to the health-care delivery. Studying the linkage between GF-funded interventions and state health care was of a particular interest to my research. This section presents results of document analysis and data emerging from interviews.

In R1, the GF programme directly engaged in the provision of ARV therapy for treatment (APMG 2009). While Semigina noted that, in 2005,the Alliance "coordinated measures to provide services to vulnerable communities that aimed *to link clients to respective services*, and to meet their specific needs" (Semigina 2009, p. 45), the *lack of patients presenting for ART* was observed by Drew, who noted that attempts by the Alliance to advocate scaling up ART provision in R1had resulted in

medication being provided, but that the demand for treatment had not been "as great or as rapid as expected" (Drew 2005, p. 13) [emphasis added].

In R6, "ensuring a level of access for communities to comprehensive needs-based and high quality services sufficient to make an impact on the epidemic" (OIG 2012, p. 3)was one of the two main strategic GF-funded directions. Among the tasks were the following:

1) Ensuring access of HIV-infected adults (particularly pregnant women), adolescents and children to ART as well as prophylaxis and treatment of opportunistic infections; and

2) Ensuring access of vulnerable population groups to targeted HIV/AIDS and sexually transmitted infection prevention measures and programmes(ibid., p. 3)

The APMG report highlighted that "successful referral from testing to treatment is key to controlling the epidemic," but noted that "the division between the sectors and lack of government resources means that many people who test positive do not get treatment" and that the linkages between all relevant NGOs and government services were "highly variable" (APMG 2009, pp. 20-21).

UNAIDS noted problematic delivery of HIV prevention services between governmental and non-governmental service providers, which remained "poorly coordinated" and presented "a risk to the sustainability of prevention programmes currently supported by the Global Fund grants and the viability of overall national prevention efforts" (UNAIDS 2009, p. 15).

Spicer et al. (2011b), studying GF-funded HIV/AIDS services in Ukraine, observed that while clients of NGO services acknowledged being "referred between NGO and government services," in practice, client referrals were "inconsistently applied and frequently consisted of informal signposting rather than formalised referral across government and NGO providers" (Spicer et al., 2011b, p.22).

At the end of R6, the WHO-guided evaluation (2013) noted *a broken link in the chain of services* after the administration of rapid tests:

> HIV positive clients are referred to an AIDS Centre. However no accompaniment is offered and *no follow up is conducted to determine who*

> *accessed or did not access health care facilities*; this indicates a broken link in the chain of services. The grant ends in 2013, which raises concerns about the sustainability of this service. (WHO 2013, p. 5)[emphasis added]

The WHO evaluation also noted the problematic referral of patients to other branches of the health-care system and concluded that:

> PLHIV are lost to follow-up at every stage of HIV care: not all PLHIV register for HIV care; not all who register for HIV care once, come for regular checkups or are seen at least once a year; not all who access care regularly and are eligible for ART have access to ART; not all who start ART continue it. (WHO 2013, p. 11)

Some particular aspects of linkage to health services in GF-funded settings that appeared in participants' responses are presented below.

4.1.4.1 Linkage to health services: referral practices

Overall, there was no uniform view among participants of what constituted a successful referral. Some participants understood that to be successful, referral meant linking a patient to an official registration:

> There is a need to work continuously with a person who has received a positive result until he or she gets registered. (028: 223)

> In the oblasts that are many NGOs – one deals with IDUs, another with sex workers, a third with MSM. Doctors complain [about this].When an NGO tells a client – you need to go to an AIDS centre –what if the person does not understand? If he is an injector… or has other issues…he may not necessarily go. So you need to work with him, take him by the hand and bring him. There needs to be a system involving psychologists, social workers, etc. But nothing is established. (013: 240-246)

Others believed that only the retention of a patient in care constituted a full referral:

> Look, here they found an injecting drug user, took him to [get] methadone…They found him and provided him with information and counselling. But the final goal is not just finding a person, or even bringing him forward for treatment. It is retaining him there. (020: 441-443)

You not only need to count services…You need to take the patient to the logical end. (019: 100)

Among the factors influencing referral, respondents noted:

- An absence of protocols: "No referral protocols" (040: 330-337); "There are many NGOs around the AIDS centre, but no referral protocol" (013: 329-330).
- Ineffective patient management: "There is no client base. Clients may enter an ST programme several times" (019: 571-586); "Client management is not well developed, there is lots of subjectivity" (018: 125-127);"Even after receiving motivational packages, only 12% turn up at AIDS centres for confirmatory testing" (019: 20-22).
- No case management:

  In 2012, the government doubled and the GF doubled the quantity of patients – to have twice as much more patients on ART... but suddenly they realised that they could not find the people. First we were worried that there were not enough drugs, now there were enough drugs, but they could not get the people. Even if the need is much bigger than this, you cannot get people to have this treatment. This means there are problems. (050: 35-44)

- Internal divisions within HIV prevention programmes in the field provided by two different PR NGOs:

  Network and the Alliance are two PRs… so they are fighting over the money, which is a natural situation, if you divide something in two, and you give one part to one actor and the other part to the other actor… So it means that you have one NGO doing screening and the other one working on adherence and treatment, but nothing in the middle. (050: 302-310)

- Lack of consensus over referral practices:

  They [PRs] report numbers… but how to get people to start going to the doctor to get tested, how to stop them from being afraid of doing this, and how to help those people who are found to have HIV become less afraid of getting treatment – these things are not discussed.(009: 92-95)

Some respondents questioned the existence of referrals and suggested there were ‘no client referral services in Ukraine at all’ (012: 377), (014:24).

4.1.4.2 Linkage to health services: HIV screening

As described in Chapter 2, HIV screening constitutes a necessary step towards official registration of HIV patients with state health care and enables them to enter the HIV continuum of care. In Ukraine, while PLWHA may get tested for HIV by ‘quick’ tests, access to ART and other HIV care entitlements begin only when a patient presents with a positive HIV test result obtained from a confirmatory (*pidtverdzhuvalny*) testing at the AIDS centre.

In GF-funded services run by PR NGOs, there appeared to be a lack of focus on a confirmatory HIV screening stage, which is an important step to complete the linkage of PLWHA to state health care. Participants reported that instead, GF-funded activities appeared to be concentrated more on the early ‘field stage’ of finding a client and giving basic outreach services such as rapid screening and counselling, and less on linking him or her to care:

> Look, here they found an injecting drug user, took him to [get] methadone…They found him and provided him with information and counselling…The lion’s share of the money is being spent on finding clients… when instead, it should be spent on retaining [them]in health care…they [NGOs] are fixated on field work… spend so much money in the field… but their work ends there. Clients do not reach the treatment stage. There is a widespread awareness about this among doctors. (020: 442-446)

Analysis of documents identified similar concerns. The APMG report called attracting high-risk groups to an early, rapid HIV screening stage a ‘success’, but noted lack of further guidance to reach the final stage of confirmatory HIV screening:

> Their [MARSs] experiences of testing in the mobile clinics were generally positive but many were unhappy at the experience of making a confirmatory test at the AIDS Centre. [A] substantial group of clients had *failed to return to the AIDS Centre to receive their confirmatory test results.* SRs mentioned that they provided incentives to clients to get confirmatory tests but no incentives to pick up the results of these tests. (APMG 2009, pp. 15-16)

The APMG report outlined such problematic practices in mobile clinics as no standards or protocols for screening and the over-testing of some MARPs[67], with some clients being tested *weekly* for HIV [emphasis added]; a lack of standards for the frequency of HIV testing; no ability to track the users of mobile clinic services, other NGO services and/or government services, which led the authors of the report to question: "Do referrals from mobile clinics lead to good clinical outcomes?" (APMG 2009, p. 22) Another report described regulatory gaps remaining, including the requirement that mobile clinics employ a doctor to inform the patient of the HIV screening results, and the inability of NGOs to provide official certification – *spravka*– of the test results (Judice et al. 2011). The Alliance's R6 final report mentions a MOH decree (*nakaz*) passing in 2011 that regulated work of mobile clinics (International HIV/AIDS Alliance 2012d, p. 24), but the fact that *nakaz* appeared in the last year of R6, confirms lack of service delivery standards before that.

A GF-funded publication notes that, according to current legislation, HIV screening by rapid tests – despite having been delivered by NGOs for over ten years in Ukraine– can only be done by the medical staff of state medical institutions, who also have the exclusive right to communicate test results to the patients (Varban et al. 2012). This publication describes GF-funded testing procedures as "approximated to the field" (*priblizhennyie k polyevym usloviam*) (Varban et al. 2012, p.26).

From participants' responses, it appeared that the GF-funded rapid screening tests conducted by NGOs were not viewed as part of state health care, nor were they counted in state statistics:

> The MOH does not report express [quick] screening by NGOs. It only reports on the tests they have done. (029: 232-233)
>
> [During] referral to confirmatory tests, coverage sharply falls. You can pass a quick test a million times, but you are nobody for the [health] system. You only become a patient after a confirmatory screening. (040: 299)

[67] Most-At-Risk Populations

> A quick test is not confirmatory…People need to go to an AIDS centre to have the second test. I know that the numbers of people who go to an AIDS centre after a positive result on a quick test is quite low. The referral percentage is low. Much less than half [of the people who tested positive]. (028: 216-220)

It cannot be concluded, based on participants' responses, that the GF-funded interventions were viewed as part of the state health-care services.

In mid-R6, responding to concerns about referral, the PR established a system of referring people who tested HIV-positive by rapid tests to AIDS centres by providing them with *talon* or *koreshok* – appointment coupons for confirmatory testing at an AIDS centre. This procedure was mentioned in published protocols for VCT[68] (2012).

Respondents mentioned problems with the coupon system: the coupons were "scarce, hard to get" (019: 344-345) and the "number of coupons was limited per day" (032: 342-343).

At the same time, the existing appointment system was overburdening AIDS centre staff:

> Our *oblast* AIDS centre is suffocating. Our NGO takes 7 out of 20couponsthat are for an AIDS centre visit. The remaining 13 coupons go to other NGOs. It means that an AIDS centre can only receive 20 people per day, which means 100 people per week. They are suffocating... Staffing is a problem. (019:286-288)

4.2 PR systems and practices of setting HIV prevention targets

4.2.1 Challenges of self-reporting by GF PRs

The GF uses a 'performance-based funding' (PBF) system in which it verifies that its money is being spent to reach the defined targets. While the principles of GF performance measurement and concerns over PR self-reporting may have been

[68] Voluntary counselling and testing' (VCT)

well-described[69], a closer look into the practices of GF target setting at the country level is pending.

As outlined in previous sections, one of the two main GF-funded directions in Ukraine was "ensuring a level of access for communities to *comprehensive needs-based and high quality services sufficient to make an impact on the epidemic*" (OIG 2012, p. 3) [emphasis added] This section presents findings about the practices of PRs setting targets for comprehensive HIV prevention services in Ukraine as they emerged from the interview analysis. In the participants' view, GF-funded 'expert groups', not objective data, determined national and regional targets, coverage and size of the vulnerable groups, and other key baseline values.

In R1, following the PBF model, the PR (Alliance) established a system of coverage indicators of three levels (Drew 2005d).[70]Among Drew's concerns about these indicators were: some of the targets being very low, some of the indicators being inappropriate process indicators, e.g. the number of information materials distributed, and the lack of adequate definition of some other indicators, such as whether 'people reached' meant unique individuals or contacts. He noted in particular, the importance of estimating the size of populations needing services such as the number of sex workers and IDUs, as this was needed to determine whether or not the programmes for these groups were reaching effective coverage levels (Drew 2005d).

UNAIDS observed a lack of national ownership in M&E data collection of HIV programmes and activities and noted that most data collection was "driven by external reporting requirements from donors and for UNGASS reporting, rather than by the national and local information needs of service providers, programme managers and policy-makers" (UNAIDS 2009, p. 26). The OIG report for R6 described the Alliance-Ukraine performance framework as consisting of a number of quantitative indicators and set-out targets to be reached by the end of a given period.

[69] A closer look at sources describing PBF is provided in Chapter 1.
[70] The agreed framework at the time was provided by WHO's M&E toolkit (2004) and presupposed tracking the level of services provided. Level 1 was the number of people trained, level 2 the number of service delivery points and level 3 the number of people reached with particular services. Level 3 indicators are the most important to track (Drew 2005d, p. 9).

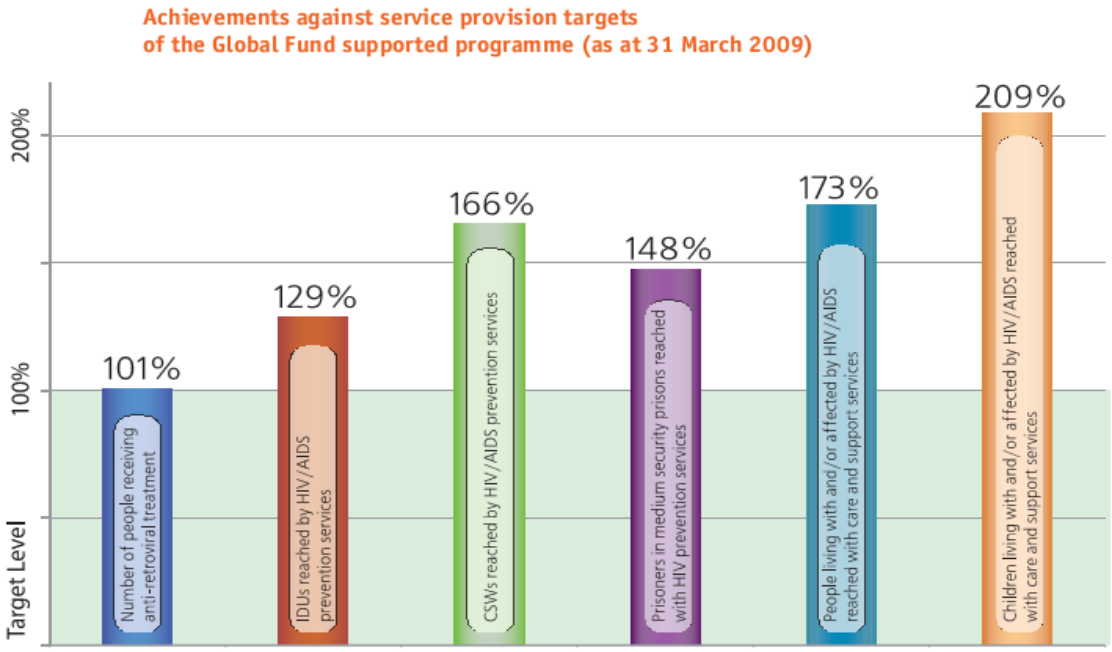
The report noted that "the targets established were not always formulated adequately and supported with validated assumptions" and recommended to the Alliance to review "whether appropriate targets have been set relative to universal access to prevention, paying special attention to the quality of prevention services" (OIG 2012, pp. 23-24).

4.2.2 The choice of targets for HIV prevention. Communist-style 'central planning': vypolnit i perevypolnit

In Chapter 1, some features of the aid delivery were discussed, such as comparison by Easterly (2006) of aid programmes with 'communist-style' central planning. Ironically, similar to a Soviet 'Five-Year Plan', GF grants were also given for five years.

Wedel wrote about legacies of communism that "figured prominently in the aid story" (Wedel 2001, p.42). One of such legacies was a 100% fulfilment or even over-fulfilment of targets – *vypolnit i perevypolnit*. Similarly, in GF-funded settings, 100% fulfilment of targets was a goal. In R1, the Alliance reported massive over-fulfilling of targets:

Figure 4.1 Achievements against service provision targets



(Alliance 2009, p. 25)

Participants reported the 'race for figures' and the need to constantly fulfil targets in SR contracts:

> There was a constant race for figures, to increase coverage, the distribution of syringes… (012: 161-62)
>
> Organisations are forced to fulfil the target numbers or else they won't get another project. (014: 172-73)
>
> It became clear to me in talks with some NGOs that, in some regions, the performance on meeting targets was reaching 100% – like in Soviet election reports – or even exceeding 100%, which was impossible. (046: 378-79)

In the Interview Guide, several questions were dedicated to defining needs and targets for HIV prevention in GF programmes. Participants' responses revealed that practices similar to Soviet 'central planning' were common in GF programmes, in particular, in setting targets. The following section summarises the main features of target setting in GF programmes in Ukraine as perceived by study participants.

4.2.2.1 No national research base to determine HIV prevention targets

Participants were asked if there was a system in Ukraine to determine targets for HIV prevention, and whether there was a national research base. Predominantly, participants noted the lack of a national, government-funded research base and said that research on target groups was conducted only with external funding:

> There was no state system to define targets. The state was forced to accept targets from PRs. (040:76-85)
>
> There was no research on risk groups... only for GF money. We don't do national studies. [We] became so spoiled by GF money, there's not even a thought that something can be done independently. (039: 611-614)

4.2.2.2 Paternalism of external approaches

Wedel (2001) outlined specific perceptions held in the FSU region in regard to external consultants in donor aid programmes, among them: applied assumptions and experience gained from previous work in the Third World, not suitable in a post-Soviet context; lack of sensitivity to the gravity of the decisions they influenced; arrogance and paternalism, "like a parent giving to a child."

The dominant, paternalistic role of external approaches came up very strongly in participants' responses. The theme of 'external' emerged in relation to: (a) the approaches and chosen methods, (b) organisations, and (c) individual experts:

(a) The dominance of external approaches was reported to take the form of 'canons', 'canvas', 'calque', and 'cement'. Participants made the following references:

> In Ukraine, it is more like some external models are being implemented, rather than [our] own [models] are being created. And these external models carry a sort of… pre-defined canvas with them. (028: 52- 55)
>
> Absolutely uncritical calquing from abroad. (039: 112)

(b) Among the dominating external organisations, participants named WHO, USAID and Soros being the most influential entities, as well as other donors, in choosing target groups in GF programmes:

> Donors such as UNAIDS and USAID were convincing the state that this is the best choice for how the money should be spent. And the state officials did not know much, besides, they were often changing. To people who were not aware of anything, they did not need any proof. (047: 363-364)
>
> ...international organisations form this policy. If WHO says that IDUs are a risk group, then it would be listened to, there is no national opinion as such. (042: 104-106)
>
> Targets were set by manipulating the priorities…Stakeholder groups would get together and nominate priorities to include in [GF] proposals. The main writers were UNAIDS or the Principal Recipients, and the Soros Fund, and if the priorities were not formulated to their liking, they were removed. (047: 39-41)

(c) The priority role of external advisors was especially strong at the stage of preparing the GF submission:

> The external experts who come to Ukraine especially to write [GF] country proposals – their opinion is a priority. If a foreign expert comes to Ukraine and sees this and that, and studies the situation in Ukraine in some reports– and then gives recommendations – that this and that should be put into the proposal – our mentality is such, that the country needs to get money by all means, so it agrees. (025: 148-151)

> The main thing is that, historically, it has always been that the international expert is some kind of god. Unfortunately. It is because this [AIDS] system is constantly dependant on Western money. (025: 205-208)

Some participants suggested that some NGOs linked to PRs acted opportunistically in target setting:

> Alliance defined target groups in conferences. Conferences were held with the NGOs that were already working in harm reduction…With the help of these organisations, the Alliance got support to define target groups and regions. The same NGOs served as a base to conduct regional assessments, and they determined the focus on IDUs. (012: 87-108)
>
> Regional targets were set by NGOs working in harm reduction. (014: 54-58)

4.2.2.3 Choosing the target groups to be covered by prevention

Drew (2005c) argued that the Ukraine's original R1 proposal disproportionately focused on IEC interventions for the general population.

Participants noted that after a GF grant transfer, prevention became narrower as PRs and the GF had guided the choice of target groups:

> The Round 1 proposal included activities on primary HIV prevention for the general population. After the grant transfer, prevention activities were narrowed to secondary prevention, but money amounts remained the same. (027: 38-42)
>
> In Round 1, the focus on prevention was shifted from the general population to the narrower needs of narrower groups. (029: 262-263)

A USAID-funded 2010 evaluation similarly suggested that target populations and regions to be funded were already identified when PRs issued calls for proposals:

> After mapping MARPs and examining local information, the *Alliance-Ukraine issues a call for proposals that identify target populations and locations for prevention programming on a regional basis*. By including examples of "typical" projects in the call for proposals, the Alliance-Ukraine provides applicants with models ... that they can adopt and modify to their particular setting.(Cited in Bergmann and Stash 2010, p. 7)[emphasis added].

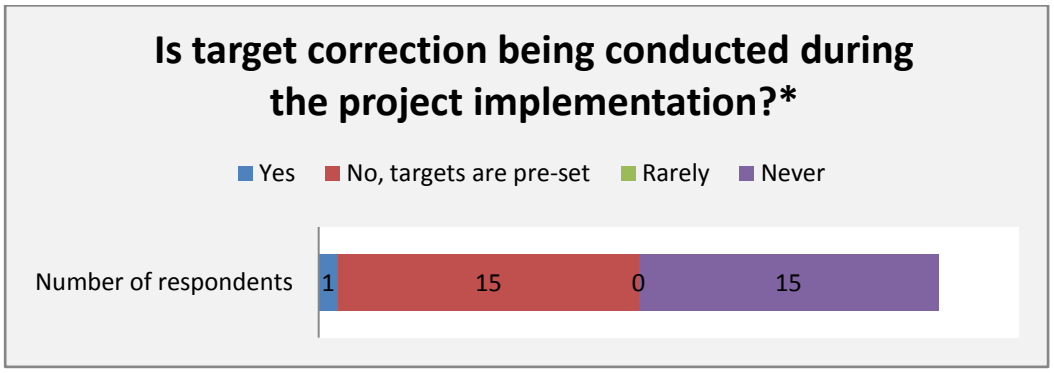
Participants reported that project targets were pre-set and imposed by PRs, and that SRs had to accept these targets, with no possibility of reprogramming:

> The reprogramming [of indicators] was not possible. You had to report for the money given to you by these [given] indicators. (004: 150-151)

> The GF targets were not flexible. It was not easy to reach [these] when the drug scene changed. The country could not back off from these indicators. (042: 491-493)

In the Interview Guide, one of the closed questions was about the possibility of correcting the targets set by an NGO after the project began. The answers distributed as follows:

Figure 4.2 Possibility of correcting targets during GF project implementation



*Only participants with relevant experience answered

Some participants suggested that GF targets were forced onto the national M&E systems and that the national M&E centre was simply an appendage of the PR:

> M&E centre was created, which was *de facto* accountable to the Alliance, because they funded salaries of its staff, but *de jure*, it was responsible for the formulation of state needs. This was a fictitious function, because these people were toothless, they served the PR [the Alliance] and were paid by it. They became anappendage – *pridatok*. (041: 98-106)

> The national M&E system that was supposed to be developed for GF money did not get launched for 10 years. Therefore, where do you get the [target] figures? My feeling was that these indicators were drawn from GF indicators. (014: 74-78)

Some participants suggested that the targets were linked to the amount of [GF] money available:

> Prevention targets were based on already determined amounts of money for each *oblast*. (009: 139-142)

> In our context, money determines the targets and results, not work…The financial process –money received, money spent, money accounted for – is primary to all other processes. (014: 130-134)

4.2.2.4 Determining the size of target groups

Drew outlined the importance of estimating the size of populations needing services when he described systems used by the Alliance in R1 to track services delivered (Drew 2005d). Throughout R1 and R6 implementation, various GF-funded studies of the risk groups' size were conducted in Ukraine, with broad discrepancies appearing in data provided (see Appendix D). In 2012, previous estimates were overruled, and all subsequent estimates on the numbers of PLWHA and the size of other risk groups were to be legislated through the CCM (the NAC) resolution.

However, prior to 2012, in R1 and R6, as expressed in participants' responses, decisions about the size of the target groups were made by PR-run 'expert groups'. The choice of members in the group and control over its agenda lay entirely with the PR:

> The size [of target groups] was determined at the meetings of the work groups funded by the Alliance. The agenda of the meeting was imposed by the Alliance – who ordered sociological research. Even though they were grant implementers, in commissioning research they were bosses. (041: 90-99)

> Target groups ..were defined by the Alliance in conferences. (012: 87-88)

Some participants stressed that it was hard to verify assessments of the risk groups' size.

> Assessing the size of risk groups is done for GF money by PRs, who organise expert evaluations of the size of risk groups. It is based on data obtained in behavioural research [by PRs]... Ukraine has no national research that could verify this data; it has no money to do such research, so it [PR estimates] is just being accepted at face value. (029: 358-370)

Interesting accounts came from participants when they were asked to describe the systems to estimate the size of the target groups in *oblasts*. In their view, these estimates used official data on HIV-registered patients and some multiplier 'coefficient' - *koefitsient*. Different participants reported different 'coefficients' used to determine the number of people living with HIV, ranging from 2 to 10:

> The number of new people with HIV is multiplied by 2 or 3 – and that's how the demand is determined for secondary prevention for PLWHA. (007: 67-69)

> The coefficient used to be 10 at first, then 7; now it is just determined locally somehow. (012: 386-394).

One participant noted that final adjustment depends on the funding available for oblast:

> This data [on PLWHA] is taken from state registration, but it's clear that this figure is low in state statistics, so they take the number of registered PLWHA, accept some general figure, and then multiply it by some coefficient…Then they look at UNAIDS' estimates, and then finally they design a figure that will fit into the amounts that the GF is ready to give. (014: 177-183)

At the oblast level, the way how the coefficients were determined, did not seem to follow any system and appeared as *ad hoc*:

> We took official statistical data, and research done by international donors, on vulnerable groups in Ukraine and looked at them. And we made a determination. There were many different studies using different methods... snowballing, RDS, others, and there was a lot of data that had many gaps… so we always agreed on some coefficient. We sat in the working groups and discussed: 'Look, the tendency is this, so how much should we cover? 60%, okay, so which co-efficient should we choose?' And then we decided on the coefficient. In 2006 it was 10, from 2008, it was 8. (019: 55-58)

4.2.2.5 'Centrally planned' needs of target groups

Participants could not confirm whether any needs assessments were conducted in GF programmes and spoke of needs as 'centrally planned' and 'determined' by PRs:

> In terms of determining the needs of risk groups, I was getting a strong sense that such sort of decision tended to be made centrally by the Alliance, and had

> less to do with understanding these problems from the perspective of the grass roots service organisations that were the sub-grantees. (049: 127-129)

> The problem lay also in the fact that the services– which were supposed to be delivered and were supposedly needed by clients – were already defined. We [the NGO] were told that – probably - clients needed syringes, condoms, and information materials, and that these needed to be included into the distribution plan in NEPs and so forth. Then we were told to evaluate our needs as we saw them. But in fact, this did not mean assessing our needs for services, but rather choosing the number of services from the predetermined list. (046: 310-315)

4.2.3 Decision making practices

After R1 transfer, Drew noted, "the open-access nature of working groups allowed for maximal participation. The most successful working groups were characterized by effective facilitation, willingness to listen to all views, professional standards of behaviour and excellent administration/documentation" (Drew 2005d, p. 1).Participants had a similar reflection, however, noted that this practice did not extend to the groups determining the size of target populations where final decisions on GF target groups were made by consensus of PR-run 'expert' work groups:

> In Ukraine in general, all working groups are held democratically, with the state sector and NGOs actively participating, as well as international experts. However, regarding studies to estimate the people who are HIV-positive, I cannot say the same picture is true. There is more imposing, like saying that there is such and such number of PLWHA, and such and such number of IDUs and CSWs. These groups have a monopoly. (013:135-144)

Participants noted the closed character of 'expert groups', frequent change of methods, and the uninterrupted chain of PRs control over the whole process. Some participants noted that PR already had control over target setting after the R1 transfer:

> After this [GF transfer],… the PR had an opportunity to rewrite the whole project 'for themselves' – and for their interests – to work with vulnerable groups, needle exchange, and methadone programmes – the directions in which they were competent. (015: 82-86)

A theme of PRs having full control over the entire cycle of reporting surfaced very strongly in participants' responses. The PR (the Alliance) appeared to have had total control over the process, from target setting to 'monitoring itself':

> PRs control the full cycle of data. (041: 336)
>
> Country targets [were] imposed by PRs. (041: 254)
>
> If a report says that 80 people received condoms, the CCM does not know how this information was received. All of the reporting systems are also developed by PRs. (026: 442-445)
>
> PRs did everything: conducted research on risk groups, ran programmes and evaluated their programmes. There was a potential for data manipulation and for presenting epidemiological data in the way they needed. (015: 20-24)

In cases where workgroup meetings could not generate a consensus, decisions were made by majority vote. Below is an account of an example of how this process was working:

> During a meeting of [GF-funded] work groups on M&E, it was announced that, in the result of a study, there appeared to be a 'small' gap in estimated numbers of IDUs in Ukraine between 280,000 and 720,000. One participant asked: 'Why was it necessary to spend so much money to generate a result with such a wide gap? I could have given this estimate off the top of my head.' With no response [from the organisers], half of the expert group stood up and left the meeting. At the end, the lower estimate was announced as the baseline and voted for by remaining part of the group – the ones that conducted the study. (013: 156-165)

Participants described failed attempts to influence decision making in the working groups:

> For five years, we tried to expand the risk groups. Why? Because we were observing how youth – from 14 to 24 years–was exhibiting behaviour that was risky [for contracting HIV]. But the workgroups expert commission of the PR only said 'No, we will only have risk groups that were already chosen'. (020:44-51)

Participants described M&E research as semi-independent and controlled by PRs:

> There are no minimum quality standards, no professional regulations. No normative base. Against what mark should the monitoring and evaluation be done? PRs conducted their own operational research…which they hired sociological research institutes to do... but… these institutions were guided by the GF, by PRs, who selected them and accepted their research reports... So

> everything that was associated with the organisation of those studies was only semi-free, semi-independent. (029: 335-346)

Participants reported lack of a research protocol or standardised methodology: "Research funded by the GF – useless. They change methodologies from year to year, change sampling strategies... we cannot determine any tendency… nothing" (041: 205-222).

Participants noted that one particular sociology group was winning PR tenders:

> Only particular sociology groups win GF research money. It is guided by the Alliance. (020: 93-94)
>
> The same company always conducted all the sociological research. (047: 403)
>
> There is a monopoly on conducting this research and new people are simply not allowed there. (013: 143-44)

4.3 Three roles of NGOs: the main assumptions

Ibrahim and Hulme (2010) in their analysis of civil society roles in poverty reduction distinguish three main roles perceived of NGOs, which in the context of HIV/AIDS NGOs would look like the following:

1) Advocacy - defending the rights of people living with HIV/AIDS, pushing for structural and system change, better access for people in risk groups to medical services;

2) Policy change – lobbying changes in government laws and regulations related to access to medical services, anti-discrimination laws, etc.; and

3) Service delivery – provision of basic services, including provision of HIV prevention interventions.

Engberg-Pedersen (2008) argues that development NGOs in rich countries have been operating as donor agencies with respect to CSOs and even to state in poor countries: "They have unilaterally decided where, with whom and regarding what they want to work", while "the concern with raising money and the various

ideological commitments have pushed them towards service delivery" (Engberg-Pedersen 2008, p.1).

As noted in Chapter 2, the mere receipt of GF funds by the INGO in Ukraine did not make it (Alliance) in any way more accountable or better advocates, especially if knowing that the INGO received the funding directly from the GF, and not as a result of a wide local initiative or quest for civil society participation. In this sense, they were 'GF-appointed advocates'. Regarding policy change - another anticipated NGO role - PRs were not able to influence the whole of national policy on HIV and only influenced isolated segments of policy (Semigina et al. 2009).

The third function – service delivery – was the key rationale behind the GF focus on NGOs as deliverers of health services. However, as discussed above, as a result of a GF programme transfer to INGO, the need to engage with state health sector distorted traditional NGO roles as well as brought in adverse outcomes on the way NGOs engaged with state actors ('quasi' NGOs). No less interesting to this study was the enquiry into the relations of PR NGOs with other NGOs in Ukraine during the delivery of GF-funded services. This section presents findings on the perceived roles and relations that surfaced between PR NGOs and other NGOs on the ground. It synthesises both findings from document analysis and data emerging from interviews, with interview data as a key source.

4.3.1 PRs NGOs and their perceived roles

4.3.1.1 Size matters: 'big' PRs

The typical narrative of how PRs tend to present themselves has to do with their being the 'biggest', 'largest' NGOs in Ukraine. This narrative was used by both PR NGOs in relation to their role as GF implementers.

Beginning from 2004, the International HIV/AIDS Alliance in Ukraine continuously claimed to be "the largest NGO in Ukraine" (International HIV/AIDS Alliance 2007, p. 35).

In 2008, after becoming a PR of a Round 6 grant, *Merezha* similarly described itself as "the most powerful HIV service organization in the country" (Network 2008, p.11).

Participants recognised the role of PR NGOs in fighting HIV/AIDS: as "big" (009: 76), "quite significant" (008: 35), and "key" (002: 264).

At the same time, participants thought that NGOs role was important because they were the only possible GF recipients:

> NGOs are the only possible recipients of GF [money]. (005: 236-238),
>
> NGOs play roles that the state cannot play. They deal with social mobilisation, advocacy. They reach out to vulnerable groups…This is an important role. (026: 405-411)

PRs were also viewed as NGO openers and creators:

> They were NGO openers, [they] supported the creation of NGOs. (007: 164-167)
>
> Considerable money was thrown [around] to develop the NGO potential. This enabled NGOs working in the HIV/AIDS sphere to assume leadership positions, from the point of view of their consolidation, development of national coalitions, NGO management development, public relations – all that you could call the high standards of NGO development. (045: 146-149)

4.3.1.2 PR roles: unclear community mandate

Issues of the PR NGOs perceived mandate and representation of communities were reflected strongly in interviews.

The Alliance

Understanding the Alliance's mandate as the main GF implementer has important implications in regard to how it relates to the GF country ownership principle that all its programmes are 'nationally owned'.

Participants were overall unclear as to whether the Alliance represented national constituencies:

> When they [the Alliance] got the Round 1 money, it was not clear what their status was… They began saying in all the meetings that they represented the entire NGO community of Ukraine. And when somebody visited Ukraine, they did not invite anybody, they just met with those people themselves. It gave the impression that they were the only NGO in Ukraine. (047: 205-209)

> It is hard to say which community the Alliance represents in Ukraine. Hard to talk about representation. Historically, the Alliance was linked with a group of injecting drug users and harm reduction programmes funded by *Vidrodzhennya* [Soros]. (028: 397-401)

An issue in question in regard to the Alliance mandate was whether it was perceived as an affiliate of an international NGO or as a national organisation. In country documents, the Alliance calls itself the 'Alliance-Ukraine' (AU) and claims to be an independent organisation. In other communications, the Alliance stresses the existing link with the home office: "One important factor behind the Alliance's success in Ukraine has been that it has from the beginning been able to rely on the expertise of the Alliance Secretariat in the UK" (Alliance/GFATM 2008, p. 37). Different sources provide various dates relating to the Alliance's status: becoming 'separate legal entity' in 2003 (Drew 2005a), 'initiating transition' in 2007 (Alliance and OIG), or 'fully independent' in 2009 (OIG 2012).

Most participants did not consider the Alliance a Ukrainian organisation but a foreign entity, or a branch of a foreign entity:

> They have a head organisation in the UK (012: 248)

> The Alliance positions [itself as a] national organisation, but everybody understands they are international. (043: 174-175)

> The Alliance-Ukraine is a 'daughter' organisation. (038: 288)

> The Alliance is an organisation where the older brother is the curator of a younger brother. [T]he position of the current Alliance in Ukraine is the position of the Alliance in Brighton. They are interlinked. *De jure* they are independent, but *de facto* they are linked... You cannot be not linked. (026: 507-509)

Participants described how Alliance's role as a PR has changed between R1 and R6, when it evolved from a more partner-like organisation collaborating with

regional NGOs, to being the sole manager, the boss. This change brought more bureaucratisation and stricter rules to SR NGOs:

> The Alliance evolved from an open organisation to [the one] dictating to other NGOs. (046: 155)
>
> The Alliance's role is changing, from NGO openers…to closers. (007: 164-167)

One participant described a role of the Alliance as a 'foreign body' in medical terms:

> The Alliance was disseminating many types of work here. But what they tried to disseminate, was very eclectic and isolated from reality here. So they were like a foreign body... (*corpus alienum*[71]) that is implanted into a master's body and the master's body is trying to reject it, but the foreign body is protected by a protective layer of money... (039: 517-528)

Some participants suggested that different ways how Alliance positioned itself were linked to reporting results:

> They did not always associate themselves with the parent organisation... They always said - it is because of us. So they used to be like this: 'If something bad was there, it is them [the parent Alliance]; if something is good, this is because of us'. When they became a Ukrainian organisation, their management became harsher, like pulling the screw tops tighter. They want to over-protect themselves. (035: 400-414)

In 2012, the published Report of the Trustees of the International HIV/AIDS Alliance (registered as a UK charity) reported $29.9 million from the GF as part of the charity's annual income in 2008 (Alliance 2012), while the money has been received as Ukraine's Round 6 grant.

Merezha: from a clear mandate to 'problematic' advocates

[71] *Corpus alienum* – from Latin 'foreign body' – an object or entity in the body that has been introduced from outside (The American Heritage Medical Dictionary 2007, at: http://medical-dictionary.thefreedictionary.com/Corpus+alienum).

Of two NGO PRs, *Merezha* was historically perceived as an organisation with a strong advocacy focus. *Merezha* was described by participants as having a clear representation mandate and being better positioned to reach the target groups:

> Network is an organisation of people living with this disease. [T]hey have a more balanced approach to GF grants. (027: 230-232)

> Network feeds from... water springs at the bottom of the lake, it is linked to communities of people and as the epidemic grows, their links will grow too, and they will have more clients. It moves in the right direction. (044: 345-349)

At the same time, because *Merezha* was more strongly perceived as advocates, the contradiction of its PR role with its advocacy role was more pronounced as noted by:

- UNAIDS:

> With its decision to become co-Principal Recipient of the Global Fund grant, the Network risks over-reaching and spreading its resources too thin. The Network continues to grow rapidly within Ukraine... Redirecting scarce resources outside the country could limit its ability to support local groups in Ukraine, which is the cornerstone of its mandate to improve the lives of people living with HIV at home. (UNAIDS 2007, p41)

- A number of publications suggesting that Ukrainian PR NGOs advocacy efforts appear 'tokenistic' (Spicer et al. 2011a).
- By participants.

Respondents noted a problematic character of combining advocacy and service delivery roles:

> It is impossible to combine service and advocacy. There are two types of organisations – watchdog and service. Combination of these two functions is impossible. You have to be a watchdog – criticise the government. Then if an NGO wants to be a service organisation, do field work, and to provide services, it cannot be effective advocate. (028: 409-418)

One participant described how *Merezha*'s role as an advocate appeared compromised in interactions with the GF and the government of Ukraine:

> The visits of the GF with high-level officials – the GF director [Kazachkine] came here several times – and high-level meetings were organised. If you take a meeting with [Prime Minister] Azarov, it was a problem. It was a warm thank you from the Network, which said in a government meeting that the year 2011 was a turning point and a wonderful year, when actually, it was a year full of stock-outs. It was a year when people died because they stopped receiving ART. So it was really a terrible year, and when such messages are brought during a meeting with the GF, it's difficult to understand … at such level of meeting, starting to lie and starting to say the opposite of what is happening, that is a big problem. I think these meetings were missed opportunities. (050: 415-425)

There were concerns expressed by participants about whether the *Merezha* membership numbers were a reflection of a community mandate and representation. Document analysis reveals various reports stating that *Merezha* had between 300 (UNAIDS 2007) and 500 members and 400 volunteers (OIG 2012).Respondents questioned whether the existing membership numbers allowed *Merezha* to be representative of the whole PLWHA community in Ukraine, which is in the hundreds of thousands. At the time of writing, its web-site reports having around 500 members (Merezha 2014).

Participants reported that in 2008, *Merezha* stopped adopting new members.

> The problem with the Network is that they are not accepting any more new members. So now it's not a membership organisation anymore. I think they said they have 300 members if I am not mistaken…But there is a certain amount of members, and now it's closed to new membership. This was supposed to be an organisation representing the people with HIV themselves. But how can you represent them when you have blocked membership... (050: 354-370)

> Network never represented communities. They only represented their members, who established them. They now have around 300 members. And they closed down membership several years ago…They have these 300, which they can always take out on the street to campaign... They refused to be defenders of rights, because now it conflicts with their role as a [GF] recipient. (047: 471-485)

'Advocates for themselves'?

Wedel (2001) noted that during communism and its 'shortage economy', the command over resources guaranteed the development of "informal patronage networks to allocate resources"(p. 165), and described how personal connections and favouritism found its way into aid programmes. Chapter 2 discussed opportunism of the 'project elites' in 'aid for democracy' programmes in EECA and FSU.

Participants suggested opportunism in GF-funded advocacy activities, with the PRs advocacy being based on self-interest and benefitting individual organisations or even individual members:

> There are no new activists that have appeared among the newly infected HIV people. All activists have been there for a very long time. But the top managers will never change, they will never leave their position. They will never take a new person onto board of directors. These people are very strongly installed… their salaries are higher... They all agree with each other. I have heard others say that these people all agree because they have a share in this money, so they are all happy. (050: 183-192, 256)

> I always smile when the executive director of the Alliance [name] and the executive director of Network [name] – principal advocates – say that they had an open-door policy with the MOH…For over a year,I don't believe there was a single individual added to the rolls of those on ART. So, what are they advocating for? A sceptic could say... they are advocating for ART, and [they've] certainly got ART for themselves…They got fairly comfortable… They would advocate for a greater number of people on treatment, but I never felt the greater numbers ever materialised... I think they were a little bit more self-centred. (045: 296-311)

> They can beat themselves on the chest and say, 'Here I am, an HIV-positive person,' despite the fact that he has been wearing expensive shoes for years and driving an expensive car and his living conditions are much different from those of other HIV-positive people in Ukraine. (047: 479-483)

4.3.1.3 PRs as donors/money distributors/rule-setters

Participants reflected on the specific roles of PRs associated with GF money management. First was the role of grant administrators, redistributing GF money:

> [The PRs] are more like money distributors. (034: 132-133).

> The Global Fund gives money to the Alliance and Network. And they give grants to organisations that are within their purview, by announcing grant competitions. (036: 85-88)

The Alliance was perceived by participants as acting more strongly in this role:

> The Alliance are money distributors. (023: 153)
>
> The Alliance is simply a funds-receiving and redistributing organisation – no more and no less. (026: 517-518):
>
> The Alliance is more like a managerial structure; it does not have much expertise in HIV prevention. Their staffs are made up more of managers, programme coordinators, financial specialists, who take on the bulk of funding themselves, so they need to manage this stream of funding, but they are not implementers, not executors of this [HIV prevention]. They are a transmission mechanism for GF money to implementers in country who have expertise and who can conduct practical activities in the area of HIV. (001: 390-400)

The second role, as seen by participants, was that of the donor. In this capacity, Alliance often presented itself as owner of the GF grant or as GF itself:

> The Alliance presented as the GF. (013: 249)
>
> In terms of publicity, you would often get the impression in the field that this was the Alliance grant… and Alliance was giving grants to sub-grantees. The Alliance logo was always present everywhere. If somebody was receiving a GF grant, there would be an Alliance logo on the vehicle or on the building... If you were a drug user, you would often see the Alliance logo all over the place, and you would assume that the Alliance is some wonderful benefactor from the UK, and possibly Kyiv, who would give grants for all these wonderful things. This was the impression that the Alliance wanted to give, that it was more an Alliance thing. It really saw itself less as an organisation managing the grant and more as a main contractor, which was giving contracts as a donor. (049: 427-447)

Some participants noted a combination of several roles: "The Alliance has two roles: the distribution of money and monitoring" (003: 132-133). Another participant saw it as business-oriented, not an NGO:

> The fact that they were so well-resourced and that they have lots of highly educated professional people working for them... doing various things that they do, gives them the impression of being less like a traditional NGO and less of – at least in management practices – but someone who is very sleek and very business-orientated, very good at PR. (049: 459-464)

The other reported role for PRs was that of rule-setters for the [GF] programmes:

> The Alliance's role as a Principal Recipient…it was very much to set the rules. (049:320-321)

Some participants suggested that by setting standards, PRs have a power to determine where the money will flow:

> [PRs] offered some standards and then, if the region accepted those standards and approved of their policies, the money would come to that region. (030: 323-328)

4.3.1.4 PRs as policy enablers

Because PRs were setting rules and policies, they were also policy enablers as seen by participants. In this role, PRs appeared to be influencing state policy. This ability was perceived as negative by some participants and as positive by others, reflecting sector differences among participants:

> …Unfortunately, AIDS state policy in Ukraine is created not by the state, but by the GF recipients. (013:530)

> The same person acts as the Alliance representative in [...] region, and as head of the regional health department. It's a complete merger. (016: 156)

> NGOs funded by the GF played a key role. Even state programmes who worked with drug users were replicas from NGO activities. (014: 102-106)

4.4 Evolving relations of PR NGOs with other NGOs: a 'culture of fear'

Articulated in many GF communications, described in Chapter 2, the perceived strength of PR NGOs as having established links with other NGOs in the country was one of the factors behind the GF grant transfer to an INGO in Ukraine. In R1, 'partnership relationships' among the Alliance and other NGOs were perceived as key to the success of the GF programme (Drew 2005). Around the same time, a pattern "to encourage competitive bidding between small Ukraine NGOs" was observed by DeBell and Carter (2006,p. 9) in DFID-funded projects.

Despite the declared NGO 'partnership', similar pattern of inequality, manifesting a shift of inter-organisational relations, began to appear after the GF R1 grant transfer (Drew 2005c). In these relations, the Alliance was seen acting 'as a donor' with the financial support going from the Alliance to the [other NGO] organisations. The possibility that organizations might receive funds from the Alliance affected "the nature of the relationship between the organizations" (Drew 2005c, pp. 14-15).

4.4.1 Growing vertical relations

The fact that one NGO acting on behalf of the GF provided funding to other NGOs to implement HIV services introduced vertical relations. The previous sections described PR systems to channel GF money to SRs and suggested that channelling of the GF funding created rifts between different organisations and led to increased competition among the NGOs.

Participants reflected on the changing nature of the relationships between PR NGOs and other NGOs in Ukraine as GF implementation progressed:

> Considerable money was thrown [around] to develop the NGO potential in HIV/AIDS [sector] to assume leadership position. And the Alliance's own leadership potential was quite high then. It assumed collegial relationships with other NGOs, at least declaratively. They were quite communicable, open, and relations were built on two-way communication. In future, it began to change. Somewhere around 2005 the changes started to occur. For us, local organisations, this lay in the dictatorship of the Alliance, i.e. in their asserting pressure on organisations. Next, their monitoring visits – initially meant to work out a collegiate decision through dialogue – began more to resemble inspections… with a seemingly accusatory tone… but because the Alliance did not officially announce its inspection policy in its relations with NGOs… this was unspoken policy… there appeared to be double standards in the Alliance's work. (045: 145-176)

In later GF Rounds, relations between PR NGOs and other NGOs became strictly vertical and contract-based. The language of SR agreements, PR manuals, and OIG reports changed to 'SR management' and 'stricter control' (OIG 2012, pp. 9, 34). As GF programmes proliferated, a growing dependency of local NGOs from PRs became more visible. Earlier, a UNAIDS report acknowledged "a widening rift between the powerful national organisations and smaller regional NGOs" (Druce et

al. 2008, p. 10). Spicer et al. (2011a) observed "a *culture of fear* derived from concerns for personal safety but also risk of losing donor largesse" identified among the representatives of CSOs in Ukraine (Spicer et al.2011, p.1751). [emphasis added]

Participants described the evolution of relations between the PR NGOs and implementing NGOs in the regions. PRs were perceived as managers, exercising power and control, and SR NGOs as passive recipients, accepting submissive roles:

> The Principal Recipients were on the day-to-day managing regardless of what other actors said or thought. Once the proposal had been legitimised through the CCM, there was little input from other actors. The two NGO Principal recipients – they were enormously powerful – and they were more or less controlling and managing a vast sum of money. (049: 310-316)

> Civil society cannot influence them [PRs] anymore. They are way too powerful now to pay attention to the outbursts of public discontent on behalf of civil society organisations that are trying to challenge this or that decision or direction of the Global Fund's work. If somebody wants to say that a Principal recipient has done something wrong, this has to be said not by one organisation, and not even by a coalition of organisations, but by the thousands of patients of this organisation. But because all these patients are left dependant on the PR's, and their health and even life depend on whether PRs provide treatment to AIDS centres, or to methadone sites, they feel dependent in this situation and will never speak out. (044:309-320)

4.4.2 PRs as 'powerful' and 'monopolies'

In regard to the Alliance, participants reported that it:

> [was] too powerful. (016: 129)

> [held] all the main management levers (041: 415),

> is a monopoly and there is no alternative. (016: 145-146)

PRs were also described as 'bureaucratic machines':

> The Alliance and Network are by status charitable organisations, but *de facto* they are almost like corporations… that are indeed in charge of big money... and because these GF procedures and all that GF bureaucracy are so important, they cannot, even if they wanted, to be anything else but bureaucratic machines... (028: 380-385)

Merezha was also seen as controlling:

> In the early days, they were possibly considered rather inexperienced as a major grant manager, but lately, they have been getting much more experience. [I]t sounded like they were starting to act a little more like the Alliance in terms of having quite a lot of control over some aspects of the grants – and over which NGOs would receive the funding and what they would do... (049: 451-456)

4.4.3 A 'culture of fear' – obedience and conformity in PR-SR relations

Participants described PR-SR relations using terms such as 'obedient', 'conformist', and 'servile' to describe SRs, while a term 'not collaborative' described PRs:

> The final transformation – a switch towards total conformity from NGOs. By the second year [of R1], the GF already had potential and experience. We, the NGO community, were the key experts in the field; we had to participate in policy making, in research on HIV prevention, where our expertise lay. But in the heads of many NGOs that believed they were directly dependent on the Alliance – it turned into a director, not an implementer, as it originally was believed to be – equal to us partner. As a result, the Alliance became expert on everything – on prevention, on policy, while we NGOs became implementers. As a result, Ukraine and the NGO community lost a powerful collective capacity that was there before. The harm reduction philosophy development stopped; it turned into stone. We became reporting machines. Sooner or later, we would ask ourselves, 'How did it happen that we *grew a dragon among ourselves*?'We fell into an inferior position, and moved from being leaders of the Third sector to servile implementers. (046: 308-344)

Participants report that PR funding cycles had an effect on organisations becoming submissive:

> They [the Alliance] only have a one-year grant cycle. It is not convenient. Because there is no predictability. You never know if you are going to win a project next year or not. Theoretically, you suppose that because you worked well, you can receive another project. But you never know for sure… This always brings in strain. (021: 160-164)

> You cannot criticise the Alliance. It is hard to criticise the principal recipients and continue receiving money. (028: 429-432)

4.4.4 Increased competition between NGOs

Practices of PRs channelling GF funding, which were described in previous sections, affected the way NGOs viewed each other. Participants reported increasing

competition and a focus on winning the grant, not clients. There was no unified view on competition.

Few implementers thought of a grant competition as 'positive':

> The way the [GF] money is distributed in the regions, is by organising grant competitions. If we talk about competitions, the best always wins. So in this sense, the competitive system is good, because it allows donors to ensure the necessary quality of work. At the same time, if an NGO understands that another NGO is breathing down its back, it will improve the quality of work. And therefore competition is necessary... It keeps NGOs 'toned', and it gives donors the instruments needed to determine the quality of NGO work and remove the NGOs that do not conform to these criteria. (024: 119-134)

However, a large number of participants saw competition as negative because it impeded cooperation and made NGOs compete with each other instead of finding more clients.

> It was a policy imposed by PRs. But we should not compete among each other, but must work together. (017: 89-90)

> Regional needs need to be determined– how much the regions should give, how the regional budgets should be formed, and then the implementers will be looked for. Now it's just competitive. (026: 474-481)

4.5. Regional power works. 'Mega' NGOs: from 'boutique programming' to largest regional recipients

Drew argued that a 'key factor' in the GF's choice of the Alliance as an implementer was in its "pre-existing organizational capacity, largely developed through managing a USAID-funded program in 2000-2004" (Drew 2004, p. 4). Semigina (2008) noted that disbursement of GF R1 funding primarily in six regions – Kyiv and Kyiv oblast, Odesa, Mykolayiv, Donetsk, Dnipropetrovsk oblasts, and Crimea – happened because of the presence of USAID programmes in these regions, where infrastructure was relatively well-developed (Semigina et al. 2007).

Chapter 2 suggested that the initial NGO networks in 'high priority' regions – previously funded by other donors – became a base for rolling-out GF-funded activities with the Alliance as a PR in R1 (in 2004). These projects, initially located

mainly in large cities in several 'high priority' regions, as the APMG report described, moved 'beyond boutique programming' in 2009. The report, however, noted that GF territorial expansion was still insufficient and described NGO work in small towns and rural areas as a 'challenge':

> One AU[72] manager said: "While assessments indicate a lot of IDUs in these areas, they are very hard to reach. Everyone knows each other: IDUs fear their status will be disclosed, they don't congregate, don't come to community centres. Also, because of the lower numbers and greater distances between them, economic efficiency is low. There are some NGOs trying to reach IDUs in rural areas, driving hundreds of kilometres, but it's very expensive for each IDU reached. (APMG 2009, p.20)

The OIG report noted: "[P]revention services ...were being provided by sub-recipients in many regions of Ukraine, with programs focused on regions of higher prevalence rates and in larger cities. Coverage of injecting drug users remained limited outside the larger regions." (OIG 2012, p. 22)

In earlier sections of this chapter it was noted how a number of regional NGOs in 'high priority' regions were able to exert much influence on the whole GF proliferation in R1, including target setting in regions.

Participants reported several large NGOs in high priority regions as receiving most of GF funding:

> To organisations that were in 'high priority' regions – there went all stream of funding, not only GF. At once money was directed there by all other donors – Soros, UNDP, UNICEF, USAID, EC, and GTZ – all rushed to work in these eight regions. And when the same organisations – which had not quite developed their capacity – began attracting additional amounts of funding, other regions remained uncovered…When everything was going to the same regions, they [NGOs] could not simply use this money effectively. When one and the same organisation receives grants from ten donors, it is hard to implement them. (012:147-157)
>
> [PR] organisations that were put in a crisis situation would revert to what they were most comfortable with. So at that time, the Alliance was working in eight or ten *oblasts* on their USAID programme in prevention, so it was comfortable to them to just slip into those with GF money. (044: 452-455)

[72] AU – Alliance Ukraine

Participants reflected on a variety of reasons explaining why the GF chose to work in high priority regions:

- These regions also had higher government spending:

> [It's] hard to say how the GF chose the regions. I would suggest that they looked at regions where enough local government money was spent on purchasing HIV testing systems, and where more tests were conducted, and where there were higher HIV rates… so where local resources were sufficient to screen wider population groups, that is also where the GF focused. (030: 116-123)

- Based on epidemiological data:

> On the basis of epid[emiological] data the regions with high HIV rates were determined, and priority regions were defined. So Mykolayivska, Odesska *oblasts* were such examples, where NGOs received much, much money. Even before the GF they received funding. And the GF also directed [money] there. (042: 128-134)

- Because of previous donor funding experience (of USAID and other donors):

> The Alliance already worked with USAID in priority regions. (045: 454).

> USAID 'high priority regions' policy… had an important influence on the distribution of [GF] funds in Ukraine in Round 1…A very high proportion was directed at those regions. And very little outside of them. The reason was that there were HIV programmes that were set up or promoted through that [USAID] programme – so it would be quicker and easier to set up additional programmes if there was some infrastructure down already – so the programme could be rolled out much more quickly. (049: 152-166)

In 2005, Drew identified the need for the Alliance to have specific partners in GF delivery, initially including *Merezha*, the Ukrainian AIDS Centre, and PATH, and argued that the need for such 'unique capacity' partners was determined by an urgent character of grant delivery and a lack of time to develop capacity when time was at stake. As was noted above, the classification of SRs into 'unique capacity' and others by PRs was maintained as a typical approach to granting in subsequent GF programmes. Participants described how PRs 'classified' NGOs in Round 1:

> In 2005-2006, I heard, the Alliance adopted a system of putting SR NGOs into three classes – 1) the ones that work for a long time and are trusted; 2) the ones that work for a long time and are less trusted; and 3) the ones that have not worked before and are the least trusted. (046: 178-185)

The document and interview analysis suggests that the nature of GF funding distribution by PRs, urgent character of GF delivery and pre-existing NGO networks affected the regional proliferation of HIV prevention services. Despite the overall numbers of 130, or 150 of local NGOs funded through the GF, according to various PR reports in different years, the large part of funding was channelled to just around a dozen of well-established NGOs who were prolific before the launch of the GF programme. The rationale for PRs engaging with such NGOs non-competitively was noted by Drew (2005a, p.10), when he described how Alliance, while in general announcing competitive tendering, was "flexible in adapting this to specific circumstances, e.g. when ARVs were needed urgently, to bring in an experienced agency to manage the non-ARV medical procurement when some NGOs had been through a previous competitive process" (ibid.,p.10), which meant engaging some NGOs non-competitively. This exemption from a general rule facilitated the emergence and proliferation of large regional NGOs – influential power blocs that received continuous GF funding because they had been through "a previous competitive process" and because deliveries were needed "urgently". These large, multiple-funded regional NGOs are referred as 'mega' NGOs in this research. The term was first used by *Merezha* in Round 6 communications[73] and referred to NGOs with 300,000 Euros and higher grant amounts. The term 'mega' NGOs was also used by participants.

'Mega' NGOs were in a better position to receive GF funding than others, as noted by participants:

> Mega NGOs in 'priority regions' are a step ahead of us. (010: 34-37)
>
> The same NGOs keep getting the money. They've got the experience of grant writing and that's why they win. (012: 278)

Participants thought that 'mega' NGOs were concentrating on too many directions of work, that this created a "geographic misbalance between regions"

[73] The *Merezha* web-site informed about a meeting held on 17-18 February, 2010 at the Kyiv office with organizations – mega-recipients on issues of R6 implementation in 2010 – 2012 (Merezha 2011). In this information, organizations receiving GF grants over 500,000 Hryvnas, were referred to as 'mega-recipients'

(012: 163), and that it was "better [to have] ten small NGOs than one large 'mega-NGO'(005: 394-98).

Needed to deliver the ARV and other supplies, some 'mega' NGOs were reported to be established directly at AIDS centres –and thus were 'quasi' NGOs:

> All streams of funding went to 8 priority regions where there were AIDS centres. (012: 152-157)

Participants also thought that because 'mega' NGOs held multiple contracts, their clients' pool was overlapping and results duplicated:

> Same organisations get the money of all donors. Programmes are made the same way, and there is overlap of activities and coverage grows – three-fold, four-fold. But there are same clients coming to all programmes. (012: 273-280)

Participants noted that, while there was a division of labour between two PRs at the national level, at the oblast level "they shared spheres [of influence]...If one organisation worked, it received part of money from the Alliance, and part from *Merezha*" (029: 495-497). This approach to allow 'mega' NGOs to receive GF money through both PRs led to creating inequalities at the regional level, blocked access to funding to new or smaller NGOs, and monopolised services in hands of one or two regional NGOs.

Some respondents reported that while PRs attempted to support the establishment of new NGOs, attempts ended by the end of R6:

> The Alliance began rolling out new organisations, but it was done in regions that were completely empty, so there was nothing there. But now they've abandoned it. So practically the same NGOs remain there as before. (017: 497-499)

Meanwhile, in *oblasts* with several 'mega' NGOs, a fierce competition between them was perceived by participants as equally problematic:

> There were *oblasts* where there were several large NGOs, and they fought like in a dog fight to get grants. (015: 151-152)

The OIG 2012 audit report failed to see through the need to diversify and increase the number of NGOs in the regions when instead, it recommended

"rationalization of the number of sub-recipients" as a means to "reduce administrative workload and improve the efficiency and quality of services" (OIG 2012, p. 9). In existing power inequalities, a 'rationalisation' could only further empower and solidify 'mega' NGOs while the need to scale-up HIV services coverage in other *oblasts* was unmet. In October 2013, the GF Portfolio Manager, speaking in Kyiv, stressed that, to maximise treatment and prevention in vulnerable groups, GF funding should be spent in 'hot epidemiological points' and that the greatest impact on the epidemic can be made in regions with higher HIV rates[74].

Conclusion

NGO-based outreach and 'rapid' test screening constituted a core of GF-funded HIV prevention services in R1 and R6, but appeared not linked with HIV care continuum, with referral protocols absent in most settings, and not recognised as part of state health care. The GF focus on NGO delivery of health services not only compromised NGOs' perceived advocacy role, but also rendered the ones that were originally grassroots, community-type NGOs to be penetrated or eroded by 'quasi', hybrid NGOs created by government officials and AIDS centres' head doctors.

Target setting was heavily influenced by PR-run expert groups, targets were pre-set centrally and passed on to regional SRs to implement. This made NGOs tuned more into reporting targets to PRs, rather than responding to needs on the ground.

Distribution of the GF funding by PR NGOs has introduced competition and verticality into their relations with SR NGOs, while a number of well-established 'mega' NGOs in priority regions were reported to enjoy multiple and extended contracts. The regional proliferation of GF-funded services followed a previously existing 'high priority regions' policy, and as such, manifested a surrender of the GF PRs earlier pledges to scale-up coverage by HIV services in all Ukraine's regions.

[74] Online webcast from the 2nd national HIV conference, from the web-site of State Services, 24 October, 2013.

CHAPTER 5. DELIVERY OF HIV PREVENTION SERVICES IN GF-FUNDED SETTINGS. DATA REPORTING SYSTEMS AND PRACTICES.

5.1 Challenges of identifying the GF-attributable services.

A number of sources analysing the GF-funded HIV prevention services in Ukraine were reviewed in the literature section in Chapter 3. Some of them are briefly summarised below. Reports identify series of gaps in service delivery areas that were important signposts to guide the field data collection.

Drew's reports on Trips 6 and 7 were particularly useful in writing this chapter - the former focusing on the monitoring and evaluation (M&E) practices in GF programmes – Drew called accurate tracking of the level of services provided "the heart of program M&E" (Drew 2005d, p. 6) – and the latter focusing on the analysis of service delivery systems by Alliance in R1. Trip 7 report also includes a list of services available under the R1 programme.

Analysis of HIV services administered by Alliance as a GF PR is contained in the APMG 2009 report, which notes that "a web of services … started to develop among all types of government and SR agencies working with MARPs[75]in Ukraine" (APMG 2009, p. 3), describes the service delivery practices, and recommends to "refine practices to maximize the efficient use of these assets for epidemic control … by *increasingly getting the right services to the right people at the right times*" (APMG 2009, p.14).[emphasis added]

A UNAIDS report, analyzing the delivery of HIV prevention services, stated that:

> The geographic scope of programmes has been uneven and the coverage of specific MARPs remains imbalanced. The scope, scale, quality and intensity of these prevention programmes remain inadequate to halt the spread of HIV among these groups and to limit the potential spread of HIV to the general population. (UNAIDS 2009, p. 14)

This report also noted that the delivery of HIV prevention services between governmental and NGO service providers was "poorly coordinated" and presented "a

[75]MARPs – Most-at-Risk-Populations.

serious risk to the sustainability of prevention programmes currently supported by the GF grants and the viability of overall national prevention efforts" (UNAIDS 2009, p. 15).

The OIG 2012 draft report described prevention programmes run by Alliance in Ukraine under the GF grants as "targeted at specific groups" and "focused on regions of higher prevalence rates and in larger cities" (OIG 2012a, p. 22).

A document entitled 'Ukraine's Impact Profile HIV' that was presented at the CCM meeting on July 25, 2013, noted:

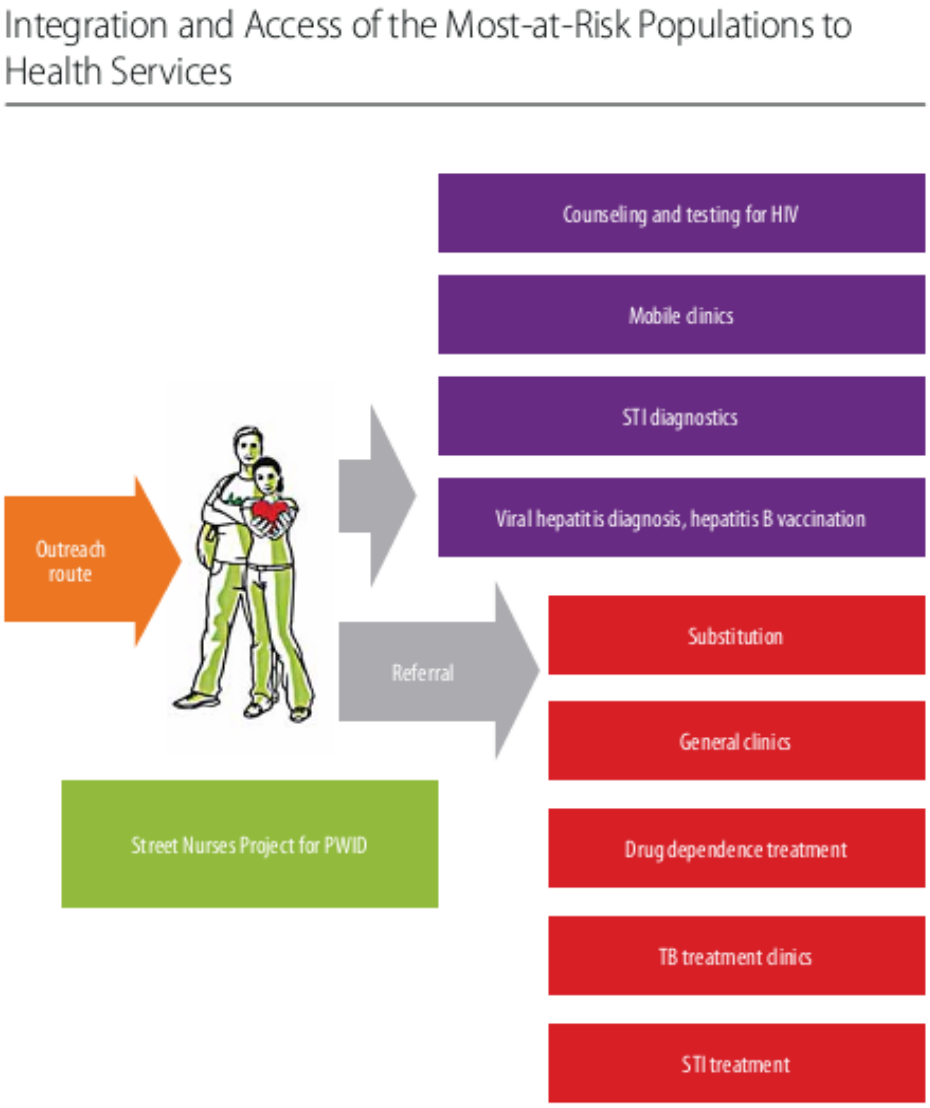
> Coverage by prevention programmes, based on estimated numbers of PWID[76], CSWs, MSM and prisoners, remains low. Coverage by majority of main prevention services (providing a condom during last 12 months, and information about HIV screening site) of such groups as CSWs and MSM, is low, and much lower the level needed to produce impact. Despite the fact that most *basic components of HIV prevention services and care are available to some people in some regions,* there are wide variations in regional coverage, and *fully accessible package of services in a broad sense does not exist*(State Service 2013). [emphasis added]

Identifying HIV services to be studied in GF-funded settings presented a challenge. Based on the literature, there appeared a discrepancy in understanding what constitutes the list of prevention services, delivery of which was funded by GF.

The discrepancy appears primarily in the PR and GF own implementation reports that typically tend to list all services – including available services in state health care (not funded by GF) – as provided by GF programmes – even if only referral to them was presumably funded by the GF. Because the GF also had input into procurement of some commodities such as ARV drugs, test systems, needles/syringes, condoms, baby milk formulas, lab equipment etc. (Semigina 2009, p. 18), PRs tend to position its programmes as part of state service delivery. For the GF, such positioning is important to demonstrate that its programmes are a part of a wider, more comprehensive system of national health services. Below, is one example of such presentation, provided in a Round 6 GF report:

> Figure 5.1 Health services for Most-at-Risk Populations (International HIV/AIDS Alliance 2012d, p.22)

[76] PWID – People Who Inject Drugs, a more recent term that replaces IDUs – Injecting Drug Users. Both terms are used interchangeably in this thesis.



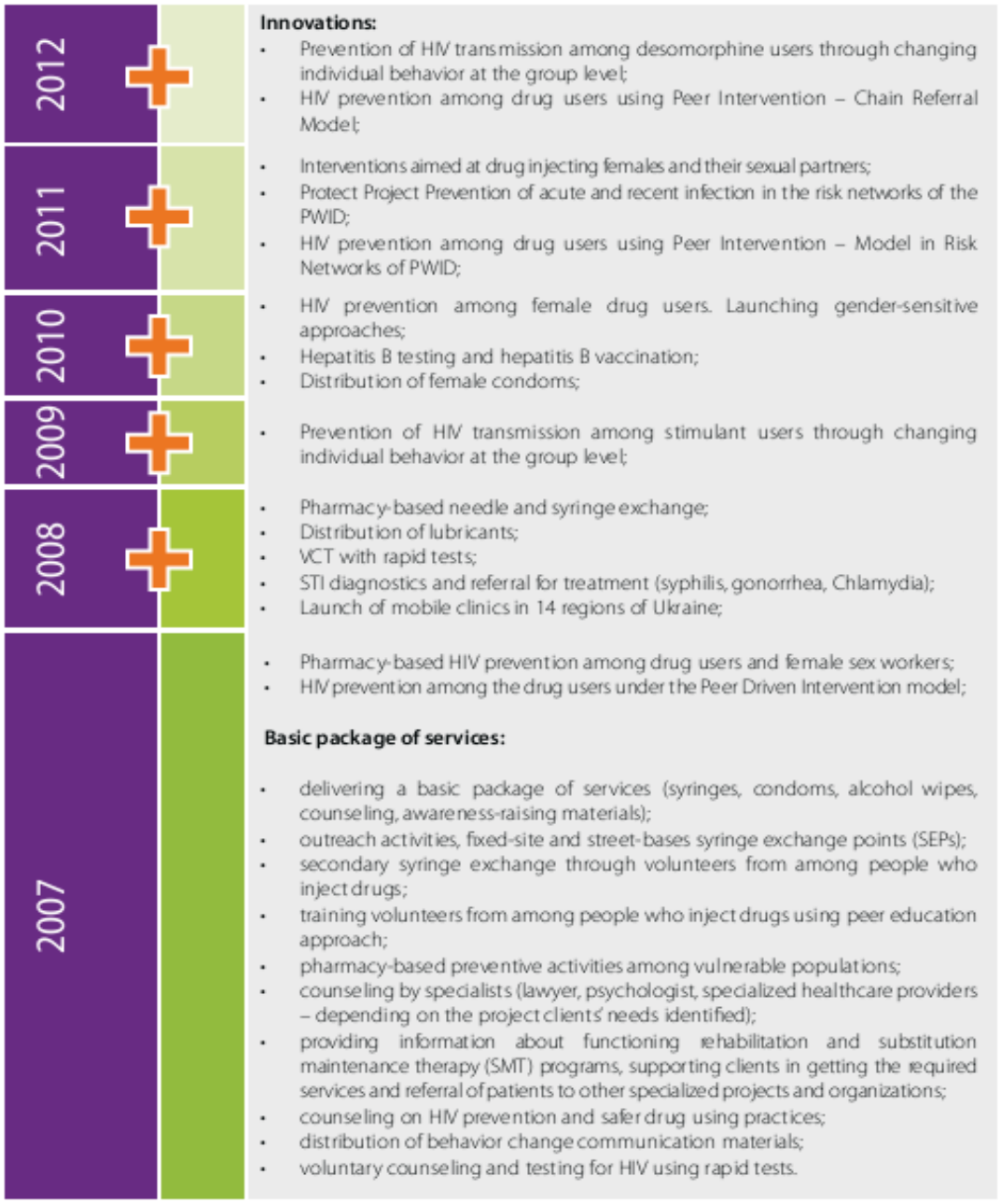
This colourful scheme shows the multitude of services for IDUs in Ukraine. Aimed to represent the GF-funded results in Round 6, the scheme, however, does not specify which of these interventions were actually supported by GF, who delivered the services, and thus obscures the 'GF zone of responsibility'. In Chapter 1, problems of distinguishing between interventions attributable to the GF, and others, funded by countries governments and/or other donors, were noted in a discussion over the "GF implementation pyramid". Such a distinction is especially difficult at the country level, and the OIG noted that any program achievements "cannot be attributed to Global Fund alone but are the result of funding from a number of co-operating partners under the leadership of the government" (OIG 2012b, p. 4). Identification of GF-attributable services represents a problem also because PRs themselves are a "prime source" of reporting data as "much of the underlying data

comes from PRs themselves"(Glassman et al. 2013, p. 44). The practices of the PRs target setting as part of data management cycle were described in Chapter 4. Self-reporting also has serious implications in reporting the delivery of services, and is discussed in more detail below.

For this study analysis, the need to isolate the services that were provided and specifically relate to GF funding was pending. Lack of a clearly established set of services represented one of the limitations for my analysis.

Drew identified provision of an 'elementary package of services' as "a core prevention approach used by GF in Ukraine in R1" (Drew 2005e, p.1). Alliance R6 Report presents the evolution of HIV prevention 'basic services' for PWIDs:

Figure 5.2 HIV Prevention for People Who Use Drugs



(From International HIV/AIDS Alliance 2012d, p. 6)

The list of 'basic package of services' is misleading. It puts both the services and activities to provide them in the same list – e.g., 'delivering a basic package of services' is included, and then 'outreach activities', of which it is a part. Further on, 'training volunteers using peer education approach' is included that is not a prevention service but is on the list, while 'distribution of behaviour change communication materials' is mentioned two times – first as a separate service, and second time - as 'basic package as 'awareness-raising materials'. 'Voluntary

counselling and testing for HIV using rapid tests' is included in the 2007 section as a part of 'basic package', and then it appears again under innovation in 2008 as 'VCT', which is its abbreviation.

The APMG report describes "the range of services provided by the regular prevention project, relevant to all populations" that includes:

- Provision of condoms, syringes (to IDUs only), antiseptics, and other expendable commodities (may vary from project to project);
- Provision of printed health promotion materials on safe behavior (leaflets, etc);
- Provision of voluntary counseling and testing (VCT) (with rapid tests), rapid STI screening and consultations, STI treatment (available to all except people in prisons);
- Provision of various consultation services (social workers as the primary consultation, medical doctors, and other narrow specialists, which vary extensively from project to project), referrals to other services and agencies, and social support, including basic mentoring. (APMG 2009, pp. 64-65).

However, the APMG report then notes that "*getting the right services to the right people at the right times"* was a dilemma (ibid., p.65).

Identification of HIV prevention services at the beginning of R6 is contained in the OIG report and includes: "educational information, counseling by a social worker, and distribution of syringes, condoms and other preventative materials"(OIG 2012b, p. 29). This list represents a core *minimalny paket poslug* in Ukraine – translated in different English language sources as 'elementary package of services', 'minimum package of services' or 'basic package of services'.

For the purpose of this study, the OIG description of services was accepted because it was assumed that OIG methods to distinguish GF-attributable services were the most reliable. Further clarifications on HIV prevention services package were then sought from the participants. The Interview Guide included questions about identifying HIV prevention interventions in GF-funded settings, about the standards of services, information on how services were documented, as well as on the focus in GF-funded services. The findings as perceived by study participants are presented below, in synthesis with the document analysis.

5.2 A focus of GF-funded HIV prevention in Ukraine

The Global HIV Prevention Working Group that surveys HIV prevention efforts globally, in its 2010 report noted that most international donors did not define "the criteria used to select the prevention strategies they support or the mechanisms for targeting prevention services" (Global HIV Prevention 2010, p.13).

As shown in Chapters 2 and 4, in the result of GF R1 transfer to an INGO, the HIV prevention approach in the GF programme was narrowed. From the original country programme that included HIV prevention in general population, which "disproportionally and inappropriately focused on IEC[77]" (Drew 2005e, p. 2) as well as on high-risk groups, it shifted to prevention only in high-risk groups. Drew (ibid.) argued that shifting the prevention focus from general population to a more narrow prevention was needed due to the nature of HIV epidemic and in order to spend GF resources effectively. This shift represented a view on Ukraine's HIV epidemic, held by most international donors, as concentrated among groups of high-risk, according to which the dominant mode of HIV transmission was by injecting drug use.

The PR R1 decisions to re-programme GF funding to support a more focused HIV prevention – reported by participants in the previous chapter – remained largely unchallenged in Ukraine. Initially, the decision to re-programme by Alliance faced lack of legitimacy as it did not have a country mandate to do so, and "the only way the required re-programming" was to happen was if the GF insisted on it (Drew 2005e, p. 34). The GF has endorsed Alliance with a broad funding mandate and this prevention focus was retained in all subsequent GF grants. Called 'targeted prevention', HIV prevention services for IDUs were a key focus of GF spending in EECA region that received 50% of all GF global harm reduction (HR) funding (Wilson and Fraser 2013), while Bridge et al. (2012) suggest around 95 % of the GF budgeted and projected investments (US$ 408 million) was given on HR for EECA in Rounds 1 to 9.

[77]IEC- Information, Education and Communication, one of HIV prevention models.

In R6, the funding received by Alliance to implement the HR programme in Ukraine was "of global significance – 69 million USD versus 89 million disbursed elsewhere"(International HIV/AIDS Alliance, 2012c). The GF representative reiterated the GF funding focus on "facilitating access to HIV prevention services – mainly harm reduction – for PWIDs" during a national HIV conference.[78]

5.2.1 The focus on drug users

> Harm Reduction campaign and OST were implemented and lobbied under umbrella of HIV/AIDS prevention in Ukraine, and were largely justified through the appeal to IDUs as potential HIV-carriers. The figure of IDU was so politicised ... and often overshadowed a figure of the HIV/AIDS sufferer. (Zhukova 2013, p. 159)

Questions in the Interview Guide asked about the focus of HIV prevention in GF-funded programmes. Majority of participants reported that GF funding was mostly aimed at injecting drug users: "prevention done by GF in 'classical' risk groups, according to best world practices" (001: 288-292), "IDUs were and remain main risk group despite changes in transmission" (020: 136), "GF is not flexible, it only gives money on drug users" (036: 314-315), "very little attention on the general population from these grants, they were primarily focused on one risk-group - people known to be IDUs" (049: 113-114).

However, there was no uniform view on how the IDUs were defined as a group in GF-funded settings. Some participants suggested that the GF programmes had a "focus on groups and sub-cultures of drug users" (019: 117-118), and were "geared at classical opiate users" (046: 387). Participants suggested the view of injectors as a risk group was rooted in the past:

> Understanding risky behavior in drug users goes to its roots in the past, when from one glass syringe – with one needle - 15 or 20 people could be injected. Now they are going away from that. And now there are disposable syringes, and they are widely available – go to drug store and buy as many as you want. But there is still a strong prejudice of syringe drug users. Because of this historical fear, more attention is paid to this group. (018: 141-147)

[78] A statement was made by Nicolas Cantau, the GF Portfolio Manager, in a conference presentation in Kyiv on October 24, 2013, the transcript of the presentation is on file with the author.

Other participants were not certain that the programmes were oriented at drug users, or specifically, at injectors: "programmes are neither oriented on drug-users, nor on specific types of drug-users" (001: 131-133), "when the epidemic began, it [GF programme] was mainly for injecting drugs users..now, injecting or not injecting... just drug users... it's not clarified... GF established its specific indicators and continues to work only on these indicators" (020: 46-49).

A number of participants thought that the choice of approach was determined by the nature of commodities to be delivered:

> It is easier to organize a programme this way because: you buy syringes, you count them, you distribute them – one to each – then count again, report, and that's all. Doing a more complex intervention is more difficult (015: 218-21),

or suggested that this focus was chosen because it allowed the PRs to spend the money quickly:

> … the interest to conduct prevention in this group was financial. Not the most effective interventions were chosen. But they were most costly and it was a good way for them [PRs] to spend a lot of money. (047: 47-59)

Some participants suggested opportunism of particular organizations in choosing HIV prevention interventions:

> [F]or prevention, the most difficult groups were chosen that are hard to reach – such as drug users – and then it was said that prevention needed to be conducted confidentially. It is very hard to prove whether prevention was really happening in these groups. Group interests of particular organizations played a role in this. (047: 39-42)

Some participants reported that the original IDU population targeted by GF has shrunk, but prevention focus did not change:

> [T]he group of IDUs … is shrinking also for natural reasons. First, because of mortality. Secondly, young drug users reject syringes. It is related to changes in the drug scene … On the market, synthetic drugs dominate. Drug user changed. The supply of drugs changed. If earlier *shirka* dominated on the market, now it is all changed… injecting drugs users are like dinosaurs – they are becoming extinct. (001:121-28)

> … there is no such population anymore that was originally defined. Half of these drug users have died, and another half disappeared in unknown direction. (047: 455-458)

A number of participants thought that a narrow focus on prevention among risk groups, promoted by GF, lowered HIV risk awareness in general population and led to risky behaviour:

> ... because of these [GF] programmes, the population of Ukraine was made to believe that HIV is mainly a problem of marginalised groups, and this creates a big problem. Because HIV is presented as concentrated in drug users and prostitutes – and nobody wants to think about themselves like this in Ukraine – that's why risky sexual behaviours are thriving. (012: 510-515)

5.2.2 Harm reduction: Ukraine an 'experiment zone'?

As noted above, R1 and especially R6 programmes in Ukraine were the largest-funded programmes to do HR in the EECA, and possibly, in the whole world. Negative perceptions on HR reduction as an external, 'Western concept' that was at odds with the culture and norms in Russia and other FSU were noted (Tkatchenko-Schmidt et al., 2007). With a prevailing focus of many publications on legal and political barriers to HR in Ukraine, noted in Chapter 2, fewer studies analyse services themselves. In R1, the HR activities conducted by Alliance were reviewed by Drew who stressed that it was difficult "to determine whether or not the programme as implemented has stayed in line with the originally-proposed harm reduction strategies because it is far from clear what those were" (Drew 2005e, p. 30).

'Harm reduction' was one of sub-categories identified by participants as a key focus of GF-funded prevention interventions in R1-R6. Similarly to a wide range of definitions of IDUs noted above, there was no uniform view on what constituted HR in GF-funded settings, how they were perceived, or how they were practiced. Some inferences of participants' statements on HR services are presented below.

Participants thought that the way the programmes were run by PRs, were based on external approaches and not adapted to existing drug use practices:

> In Ukraine it is attempted to introduce some international standard recommendations, despite that the existing drug use culture is characterized by several factors. In comparison to Europe, where drug use is mainly individual, in Ukraine drugs are being used 'in a circle' – old Slavic habit – we sit in a circle and pass over the syringe. Second difference – in Ukraine

> drugs that are common in Europe, a-la hashish, marijuana - are not common. We have locally made opiates that produce strong dependence..Third difference – drugs are often sold already pre-filled in syringes. What quality is of that syringe, who bought the needle, who handled it – nobody knows. This is never studied. Often people have to give up these clean syringes at the point of sale in return for the pre-filled one… as part of payment… for [drug] (029: 546-560)

> Harm reduction philosophy – in the form that it came to Ukraine – was not adapted. The main accent and philosophy should have been for us to penetrate the communities, and try to find other mechanisms..to move away from syringe exchange that is purely technical in its nature. But all [GF] coverage indicators were geared at the number of syringes distributed. It was the main accent of work. Why was it bad? It was bad in long-term sense. Because the people with little understanding of harm reduction philosophy were misled that by such technical means we can solve this problem. (046:259-270)

In participants view, promotion of external approaches by PRs has turned Ukraine into an 'experiment zone', a 'guinea-pig country' for HR:

> We were a working base for applying maybe all the philosophy that lies behind that approach.. All different approaches were tried on our drug users… as large numbers of drug-users were involved, with different [drug] use types, different in social status etc. (025: 160-167)

Some participants believed that implementing HR before changing the legal environment for it compromised the approach and was detrimental on its perspectives:

> [T]hese programmes were absolutely perpendicular to Ukrainian legislation. Without changing the legal environment you cannot implement them. Anybody who is implementing them – be it AIDS center, narcology doctor, NGO - becomes a hostage of drug law. The implementers were put in trouble by this. People took risks. If a narcologist said yes to implementing this programme, he knew the procurator general may be coming... or maybe not. So it was on this fragile anticipation that maybe it will pass. But if doctors knew they could be subject to prison terms, and some were already arrested, they would refuse this money at once. The programmes were presented as though they could be done. Methodology and drugs were brought. But possible criminal liability was not outlined. So the dangers were not clear. Doctors who did it were suicidal. Such programmes can be implemented with consensus between MOH and Interior Ministry. There was none then, and there is none now. Reach consensus first and then show that you can do programmes. But they [PRs]…took the money and started implementing what they declared. Even if they already knew there would be resistance. They

were misleading the Global Fund about the risks that existed in country. (039: 418-439)

Some thought that because HR programmes linked to the MOH as a state partner, they bypassed other important state agencies:

> [T]his is a drug-abuse problem, this is a law and order problem, there is a medical side to it – let's work – you at the Ministry for Interior work out your side, and the Ministry of Health will have and a special coordinating officer ... next to your office and help you solve this problem. This was not going to happen... As soon as the Ministry of Health had it – this was a kiss of death. (045:296-301)

Using an approach that was not sufficiently approbated in country and viewed as external also meant that harm reduction services would not be supported by the state and not be sustainable: "if not for foreign money, they [state] would never have allowed such things as harm reduction..." (021: 296-299), "there is no guarantee that these programmes would be sustained beyond the life of the grant" (049: 499-500).

Some participants also felt that the way harm reduction was offered, was not perceived as fair in society:

> You may say that harm reduction is needed. But how can you explain it to an old lady who comes to a drugstore to buy a syringe that costs 40 copecks or 1 hryvna[79] from her tiny pension because she needs diabetes shots, and here comes an injecting drug user who gets syringes for free. She would not be happy about it. (016: 31-33)

> ..there were naïve assumptions that because of AIDS, the drug policy will be relaxed…It is not so here in Ukraine. Instead it brought an irritation in poor society. Why should drug users receive this for free? So the drug policy did not relax, there is no consensus on this… we have different public attitudes here. (039: 477-489)

A number of participants suggested that the scale of programmes was not sufficient to have an impact on the epidemic[80]:

> The overall need that you need to fill in terms of harm reduction services was so vast – it was really going to be very difficult to do much good with what were relatively small programmes and relatively small numbers of people

[79] About 0.07 pound sterling.

[80] As of January 2012, 6,632 people were reached with OST programmes in Ukraine (International HIV/AIDS Alliance. 2012a, p. 10). With the number of PWID estimated at 290,000 (Nieburg and Carty 2012, p.4), the former figure represented 2.3% of the projected PWID population.

> receiving harm reduction services ... that was simply not going to do very much in terms of overall epidemic on the population level. (049: 492-98)

Needle and syringe exchange programmes (NSPs) were a significant part of GF funding. NSPs came up as a sub-theme in interviews linked to 'harm reduction'. Participants noted the following aspects of needle exchange services:

- Lack of "uniform approach to instrumentarium (paraphernalia) disposal" (002: 393);
- Only isolated parts of harm reduction were being implemented, not linked with other services and not achieving a desired effect: "needle exchange makes sense if it is not done separately, but tied to other services" (003: 375-376);
- Needles need to be of good quality to attract drug users but were not always available in GF programmes. "Needles alone were not a motivator: [quality] directly influences attendance. If quality is bad, person won't come again" (002: 543-545), "A clean syringe in itself cannot be a motivator. Syringes are sold without prescription in drug stores. Syringes are cheap. In many developed countries where NEPs ran, syringes were by prescription only, and in limited numbers (015: 294-298).

- Risky legal environment for NGOs: "needle exchange is too serious a problem to give it to NGOs. Social workers are not protected from injuries, utilization is not legally defined for NGOs to do it" (046: 227-239):

> [N]eedle exchange – headache for NGOs. Nobody thinks what they will do in relations with law enforcement. Name me at least one NGO who has a license for this practice and can conduct it independently. None. There is a loose legal basis for NGOs in harm reduction. NGOs did not have license to deliver needle exchange services.(005: 220-232)

Some participants reported that after 2010, the needle exchange has stopped completely in GF programmes and only needle handouts remained: "now there is no needle exchange, only distribution" (017: 369-370), "after 2010, no needle exchange, only distribution" (019: 395).

5.3. Documenting HIV prevention services: challenges of data reporting

> It is usually impossible to foresee all possible issues which might arise after reporting and registration systems are designed. Moreover, even those projects working in the same sphere might be quite different in terms of services provided, activities implemented and approaches taken. Thus it is very important for *funding agencies* to find a proper balance between necessary standardization and flexibility when developing the system of programme monitoring. (International HIV/AIDS Alliance, 2008, p.67)

Chapter 4 described significant PRs discretion in choosing targets and the full PR control over the data reporting cycle. This section focuses more closely on the process how the data on delivering HIV services was obtained and documented in GF-funded settings.

The 2011 MEASURE report of Alliance-provided HIV prevention services identified key features of the service delivery process and how it was documented:

- HIV preventive interventions for MARPs are largely provided by the NGOs' social workers (SWs).
- The interventions consist of a large variety of activities that are offered, most of which are similar across organizations within the same MARP sub-groups. At their enrollment in an NGO's program, *a client* has an intake interview with a SW during which a complete baseline assessment takes place. The client is also assigned a personal ID code. At the time of the audit, *the coding system* was transitioning to an Alliance-wide eight-digit code based on a number of initials, birth date, and gender of the client. During the audited period, the old coding system based on shorter codes was still in use.
- During the visits, SWs document the services they provide on a daily report form in which the client is identified by her or his ID code only. The format for the daily report form is provided by Alliance, but can be adapted by individual NGOs according to their needs. A number of *variations on the format were found at different NGOs.* The form contains *information on which services were received: used needles returned, needles dispensed, used syringes returned, syringes dispensed by size, condoms, disinfectant swabs, lubricant, information*

> *leaflets, type of consultation (information provided: SW, VCT/HIV, VCT/STD), sent for confirmation HIV test and other services. (food support, hairdresser services etc.)*[emphasis added] Most daily report forms have a heading 'Other' that can include a variety of services depending on the NGO; mostly it includes services such as pregnancy testing, female condom distribution, hairdresser services, etc. The SWs hand over the daily report forms to the documentator on a daily or weekly basis, depending on the NGO. The documentator enters the data from the daily report forms in the SyrEx database. (MEASURE Evaluation 2011, pp. 9-10)

As emerging from interviews and document data, specific aspects of services documentation were described:

- coverage by services;

- identifying a 'minimum package of services'

- identifying 'clients' or services, 'new' and 'old' (continuing) clients;

- client coding systems;

- computer database used by PRs to document data.

The sections below present findings on these topics.

5.3.1 Lack of standards of HIV prevention services

A key challenge in assessing the prevention services in Ukraine lies in the absence of defined standards of services. Existingstate standards are applied in treatment of PLWHA at the state health institutions, as noted by OIG. To identify and assess other services, including HIV prevention, is challenging because of "absence of national service quality standards for prevention, care and support" (OIG 2012b, p. 25).

Uniformly, participants reported the absence of standards in NGO service delivery settings: "There are no minimal standards of quality. There are no

professional regulations. No norms. So – by which benchmark you conduct monitoring and evaluation? And how do you report?" (029: 257-261), "Regarding standard package of services, there may be different services in different visits" (003: 349-350).

A new legislation passed in 2012 on 'social contract' services was supposed to streamline general standards for social services, however, it was not in place during R1-R6 grants. Some participants reported knowing about state introducing such standards: "there are now moves by state in direction of quality standards of social services" (002: 564-66), "there were protocols, norms beginning to be developed, and now a law on social contract is passed" (017: 130-132).

Participants thought that if NGOs were able to receive state funding, it would bring more standardisation of services. However, some participants were concerned that state-funded services might have different priorities from donor programmes: "There is no experience of social contract. No money was given on this before. So if donor funding ends - all our regional NGOs – with their computers, capacity, target groups - will not be funded. And they [state] will certainly put money to their priorities" (036: 191-95).

Others thought that standardisation of services was not always beneficial and it was clear that not all NGOs wanted such standardisation:

> We need time to transfer on state funding. But it should be gradual. Standartisation is on one side good, but is also problematic. Here you need one thing, and there you need another.Here one thing will be effective, and there another. Donor programmes allow for flexible services. (017: 317-322)

> It would be good to standardize [HIV] services. However, this is a double-edged sword… it all depends of how we define the quality of a service… (sighs)… so if we define standard, we need to cost it… and then you can cover less people for same money… so you need to approach this sensibly… (024:365-68).

5.3.2 Handling the data: problematic historic traditions

Ukraine has a rich historical association with data distortion that long precedes the Soviet period, as part of the Russian Empire, where practices of

manipulating information were wide-spread. The term 'Potemkin Village' –"used, typically in politics and economics, to describe any construction (literal or figurative) built solely to deceive others into thinking that some situation is better than it really is" [81] – originates from Ukraine. The novel *Dead Souls,* a Russian literature masterpiece written by Ukrainian-born Nicolai Gogol, satirizes corrupt tsarist Russia. The main character, Chichikov, travels across Russia buying non-existent serfs from landowners – dead souls– to build an estate on paper that does not exist in reality. The serfs are accounted for on landowners' census and other records, but they have died. The Chichikov's hopes of amassing enough dead souls to gain influence and power do not gain him anything in the end.

Manipulating information was a typical feature of the Soviet system. Stalin's cynical saying – "it is utterly unimportant who voted and how, but what is important is who will count the votes" (cited in Bazhanov 1992) – was widely used in all spheres of the Soviet life. In the planned economy, reporting 100% of targets fulfilled or over-fulfilled - *'vypolnit i perevypolnit'* - was typical in official statistics. The real figures were available to a select few senior party members. A typical case of concealment involving the Chernobyl nuclear plant catastrophe was described in Chapter 2.

In *Collision and Collusion*, Janine Wedel described pre-existing "legacies of communism that would figure prominently in the aid story" (Wedel 2001, p. 73). She described an *"*entire language developed under communism to describe the practice of creating fictions to please authorities" when referring to a Soviet practice of *ochkovtiratelstvo* – "literally, to kick dust into someone's eyes, meaning to pull the wool over someone's eyes or to fool the observer, boss or do-gooder". She argued that such practices were reinforced in donor aid programmes in the FSU:

> Just as they [managers] had engaged in certain "fictions', ranging from subtle readjusting of figures to outright falsification, to meet pre-specified targets under central planning, so they employed the same kinds of fictions in the aid process to please the donor community... Just as there were obvious reasons for the original development of *ochkovtiratelstvo,* so there were reasons for

[81] The definition is from Wikipedia. The term derives from Count Potemkin, a Governor of Southern Russia, and a favourite of Catherine the Great, who allegedly built fake settlements along the banks of the Dnieper River to impress the Empress during her travel to Crimea in 1787.

> its use in the post-communist era. By unwittingly encouraging the habit of *ochkovtiratelstvo,* aid served to reinforce some of the old communist ways. (Wedel 2001, pp. 74-75)

Because donors were unaware about such pre-existing practices, aid programmes in the FSU were often "following in Communism's footsteps" (ibid., p. 165).

Among others well known Soviet practices were *blat* (the use of personal networks in order to obtain goods and services in short supply or to influence decision-making), and *pripiski* (false reporting) (Ledeneva 2000, p. 7). Bridger and Pine (1998, p. xiii) note that in the context of post-socialist transformations, "the effect of many foreign interventions is to accentuate previous hierarchies". Sampson (1997) spoke about 'project elites' who accumulate donor resources and re-distribute them among closed circles, as was mentioned in Chapter 2.

The GF reporting systems as a part of the PBF model, rely heavily on self-reporting by PRs, and may present a high risk for data manipulation in the post-Soviet context, and possibly in all contexts incentivized not to report under-performance. Some features of data reporting systems and practices in GF-funded settings in Ukraine are described below.

5.3.3 Data reporting systems used by PRs: different databases, the same owner

Data on provision of services, including how it is documented and reported, represents an important part of the GF PBF system. However, as a CGD Report notes, "given that much of the underlying data comes from PRs themselves – it is not surprising that "data quality" is a recurrent concern addressed in GF policies" (Glassman et al. 2013, p. 79).

Drew called accurate tracking of the level of services provided "the heart of program M&E" (Drew 2005d, p. 8), and acknowledged a "strong and clear focus on tracking the numbers of people reached with essential services" in R1. He cautioned, however, that "reported information on key indicators needs to be carefully verified and supplemented by data on quality of services and their effects" (ibid., p. 1).

In GF programmes in Ukraine, data obtained from provision of HIV services, numbers of clients covered, etc. is aggregated by a special automated database called SyrEx[82].

The Alliance manual describes SyrEx as "an automated records management system, developed by International HIV/AIDS Alliance in Ukraine with financial support from the Global Fund" for monitoring and recording HIV prevention programs among all vulnerable groups, having the following key functions:

- registering clients;
- recording commodities and services provided;
- recording trainings and other group events;
- generating reports by different criteria; and,
- aggregating and transmitting data from multiple sources.

(International HIV/AIDS Alliance in Ukraine, 2008).

A recent report by the International HIV/AIDS Alliance in Ukraine refers to "a state-of-the-art monitoring, evaluation and reporting system" that "is now used as the official monitoring and evaluation framework for the national HIV response".(International HIV/AIDS Alliance 2014, p.25)

Earlier, Drew noted confusion over the use of M&E software in Ukraine: "[I]t was not completely clear what system was being used or how compatible these various systems were with each other" (Drew 2005d, p. 5). The OIG reported that PRs routinely collected data on services provided by sub-recipients and analyzed progress against targets (OIG 2012b, p. 24).

Four M&E management software systems are mentioned in documents related to GF-funded programmes in Ukraine: SyrEx, SyrEx2, Case, and Case Plus. The two SyrEx systems were used by all NGOs that report to Alliance (MEASURE Evaluation 2011, p. 8), both under its USAID SUNRISE project and in GF-funded programmes. The two Case systems are used by *Merezha* to document care and

[82]The name SyrEx originates from the 'syringe exchange' - information management system used by Alliance sub-grantees working in the sphere of HIV prevention (International HIV/AIDS Alliance, 2008, p. 7). The full name of the software is Automated Records Management System In Harm Reduction Programs – SyrEx.

support services for PLWHA. PRs use data generated from the Syrex and Case systems to report on 'performance-based' indicators to GF.

The MEASURE Evaluation (2011) provided a detailed description of how data on services is gathered through SyrEx in projects (p.8). The APMG evaluation considered SyrEx an "important addition" to the M&E mechanisms operating in Ukraine, and "an invaluable tool" to document and measure the progress of programme, but noted the need to connect each service administered to the client served using the unique client identification codes, so that "confidence in statistics derived from SyrEx can be substantially increased" (APMG 2009, p. 17).

Review of available documentation shows that all four systems are variations of the same SyrEx system, created locally in Ukraine by a private IT software company (Borschev). A number of key managers of Alliance Ukraine are among the individuals holding ownership rights to the SyrEx software, which the GF paid for.[83]

Participants reported that the PRs required SRs to use their data collection systems, offered no choice between different data documentation systems or discussion of whether those chosen were suitable for users. "The reporting database systems are being imposed. The SRs cannot choose anything else" (028: 151); "It is not possible to choose a different system" (003:199).

Participants had the following opinions of the SyrEx software:

1) SyrEx is owned and therefore controlled by Alliance: "this system was invented by Alliance itself" (048:140); "SyrEx gives Alliance "a monopoly on data" (041: 279);"because Alliance owned SyrEx, they could correct it at any time" (042: 247); 'SyrEx- a monopolist programme" (041: 229):

> SyrEx is Alliance owned [software] programme, and they can do whatever they want with it. All kinds of changes can be put in or put out. The one who orders, controls the results. (047: 540-548)

2) This database is not possible to be verified or controlled externally:

[83] The names and affiliations are on file with the author.

> NGOs are accountable only financially in Ukraine. Programmatically, they only report to Alliance. CCM has no relation to this reporting. These reports are just presented to CCM, nobody knows how to verify them, and if report says that 80 people received condoms, the CCM does not know how this information was received. All reporting systems are developed by PRs. (026: 436-445)

> SyrEx validity is questionable. Because clients are not required to come in person, but only to be registered. (014: 312-314)

3) Difficult to work with: "silly system" (003:294), "not reliable" (012: 334), "paradoxical" (042:320), "there was not one quarter when there was not a problem with using SyrEx" (006: 433).

4) SyrEx data is only used to report for GF money: "SyrEx is used to monitor internally the GF projects" (025: 117), "data from SyrEx used to submit money requests to GF" (043: 368).

5) Data reported is not used for state or regional HIV programming and cannot be used for state statistical purposes in Ukraine: "SyrEx is not a programme to prepare state reports, we kept parallel calculations" (003: 188-193). "SyrEx data is not used in national planning" (025: 116); "This data is ..only used for GF and Price Waterhouse [LFA], because it cannot be operational in Ukraine" (012: 411-416).

6) SyrEx aggregates one-year project data, and is then re-set at the beginning of the next project year: "database closes at the end of project year" (021: 390); "Clients are counted during one project cycle which is one year. The next year, the database is annulled, and if clients come, they are counted as new [clients]" (028: 192-93).

7) PRs conduct expensive conferences and trainings on how to use SyrEx databases: "expensive training about methodologies for collecting data. It is not needed by NGOs. They are not linked to methodology, they only provide services. Much money is spent on SyrEx training" (041: 548-553); "trainings are held in the most expensive conference halls, or in resorts – and it is a Feast in the time of Plague – you cannot call it otherwise. This wastes a lot of money" (040: 206-209).

8) SyrEx is not certified in Ukraine:

> Why didn't they [PRs] adopt a system that was legally normalized? Because they would need to certify their system in ministries that regulate coding and certification in Ukraine. But they were probably afraid that their database

> would not pass through these systems – on how they ensure data protection, etc. But most important, they did not have an obligation that this programme should be adopted by the state. They simply needed a reporting system to demonstrate to GF – electronic system to show to GF how they conduct the work with GF money. (048: 248-256).

5.4 Data reporting practices as reported by research participants

5.4.1 Coverage and its importance. Evolving language of 'coverage'

The definition of "coverage" in the provision of HIV services deserves a closer look. Drew defines coverage as "a measure of how much a service is used" (Drew 2005e, p. 8) and notes that coverage of clients by HIV services as the least well-defined but most disputable indicator. Having analysed coverage by services for IDUs in Round 1, he noted that the levels remained "significantly short of the target"(Drew 2005e, p. 11). The UNAIDS External Evaluation identified coverage as one of the critical barriers to the national AIDS response and noted "limited capacity of NGOs to further scale up services to meet ambitious targets for coverage, especially among population groups and in cities and towns with limited or no coverage" (UNAIDS 2009, p. 33).

The Alliance M&E Manual embarks on a lengthy description of how to define coverage: "Different terms are used in international literature to reflect the number of people reached with a specific package of services during a certain time period. It is often referred to as either coverage or uptake. Sometimes the term coverage is used to define which geographical areas have prevention or care and support projects, thus showing a potential possibility for vulnerable groups to ... receive services, while the term uptake is used to define the actual contact of client and service provider. In this manual, we use the term coverage *to describe actual numbers of people reached*" (International HIV/AIDS Alliance 2008, p. 45). Further on in the manual, coverage is defined as not actual numbers of people reached, but as "the number of people who receive a service expressed as *a percentage of those who need the service*. Thus, for coverage calculations, the number of people receiving the service is the numerator and the number needing the service is the denominator" (ibid., p. 46).

Analysis of PR reports suggests that both the numbers and percentage figures were used to account for coverage. There is wide variation in coverage figures in different reports in relation to GF-funded prevention. For example, the Round 6 Summary Report published by Alliance (2012, p. 5) cites: "the cumulative coverage (in 2007 – 2012) with prevention services was 429,778 people who inject drugs, 74,908 sex workers, 52,469 men who have sex with men, and 146,535 prisoners". Further on, the same report on page 8, citing another GF publication on Ukraine, mentions "more than 160,000 people who inject drugs covered with prevention services" within the period from 2005 to 2011 (Alliance 2012, pp. 5-8). A Factfile map on the International HIV/AIDS Alliance web-site presents the coverage figures for Eastern Europe (where Ukraine is the only country having their Linking Organisation) as: 464,854 people in 2011, and 262,131 people in 2012, reached through HIV prevention services there (International HIV/AIDS Alliance n.d. 3).

The evolving language of 'coverage' used by PRs was another feature in GF-funded programmes. The language used to describe coverage changed over time, from '*covering* high risk groups with 60% services' in (Drew 2005; and Smyrnov 2009), to '*reaching*' most-at-risk-populations with prevention services (Alliance 2012). A GF-funded brochure in 2013 spoke of IDUs who '*had access* to prevention services' (Alliance 2013). The OIG final report does not use the term 'coverage' at all, but rather uses two terms – 'clients reached' with prevention services and 'clients served' (OIG 2012b, p. 30). [emphasis added]

There was a discrepancy in how different terms came to be used: 'reached by services' meant 'reached once' while 'covered' meant reached by regular services. The APMG report noted when observing the data collected by PRs, that "ever reached" and "annual reach" figures were generally referred to as "coverage" (APMG 2009, p. 17).

In Round 6, the *Merezha*, responsible for the care and support component of the GF grant, used the CasePlus documentation system that is a technical variation of SyrEx. The following definition was used for a 'covered' person living with HIV as:

> Person Living with HIV (adult, child affected by the epidemic) – who has received a minimum package of (two) services during the reported period (Salabai 2011, p. 16).

Coverage by services in GF-funded programmes and its definition was one of the thematic areas of the Interview Guide. Participants' answers were spread, without a common approach and with a wide variability in understanding of what was meant by coverage. In some accounts, it was "a very variable indicator" (002: 243-244), while in others, "coverage figures were fixed" (046: 420).

Among other features of coverage noted by participants were the following:

a) Cumulative counting of clients of HIV services was reported in R1:

> .. at the beginning there was a different counting system. It was cumulative… for several years. Some people could come several times during this time. Within a year, we could say more realistically how many people came. (019: 70-74)

> [Participant 017]: First we had all cumulative data. Horrible – there were tens of thousands there – cumulatively - and we understood that really we don't have so many… so we started to deduct some figure ourselves… as a kind of mean arithmetic.

> [Researcher]: how did you calculate that?

> [017]: Don't know. Alliance deducted. So this year we covered.... [number], but one third of them are 'dead souls' – they will never come again. I do not know how this was calculated. They conducted surveys or something. Alliance said – here is what we counted. They impose their counts on us. (017: 393-400)

b) Coverage data had a high variability – it could mean different things in different places, or not providing the whole package of services, but only some of them:

> Coverage can be one thing, and can be the other thing… there may be a coverage, but with low quality services. (002: 234-235)

> Coverage also meant distribution of brochures. If a volunteer distributed 100 brochures, it was considered 100 clients were covered. (003:112-114)

c) Coverage figures are not important because clients are not linked to care: "coverage… NGOs show 60% - but of what? It is not linked to care" (020: 567-570).

5.4.2 A 'minimum' (basic) package of HIV prevention services and its evolution

A core prevention approach used by GF in Ukraine is based on provision of an 'elementary package of services' (Drew 2005e). Data obtained from provision of HIV services, numbers of clients covered etc. is aggregated through the SyrEx database.

Questions in the Interview Guide asked participants to define a minimum package of services. Participants gave the following descriptions: "Syringes. Counseling by social worker. Information material. Condom. Spirit wipes – a set of supplies" (017: 510-511); "minimum package of services for MSM is: condom, lubricant, information material, consultation. Regarding HIV screening, not sure it is part of a minimum package" (028: 209-212).

While some participants suggested that minimum package existed in both R1 and R6 programmes:

> When we only started to work, the minimal service included handing out paraphernalia and informing. Later, counselling was added, and then work of psychologist. Evolution was going from the point of view of developing quality, the quality of service itself, and increasing the range of services (diversification). (024: 291-295)

But others thought that reporting on the minimum package began only in Round 6, in 2009 and was not done in R1.

Receiving the minimum package of services was linked to the frequency of a client's visit. Participants were asked how often a client needed to receive HIV services to count as covered. The answers suggest two variants of reporting options:

- One time: "In SyrEx– once in a lifetime – and already covered" (025: 582-83):

  "[017] Once. That's all. He came, received, and already was counted as a programme participant, and as covered.

  Researcher: And if he did not come again?

  [017]: Well… if he did not come… he did not come… (017: 385-390)

- More than once – including 'once a month' to 'two or three times per quarter'.

Regarding the number of services received, there was no uniform perception of what qualified. Some suggested "covered by [minimum] service was based on two services received" (024: 282-284). Others suggested that clients were not receiving minimal package of services in each visit: "standard package of services - there may be different services in different visits" (003: 349-350).

A large number of participants reported that the nomenclature of prevention services and the number of people to be covered were already pre-determined by PRs (Alliance), and that SR NGOs could neither define the needs for prevention services, nor choose services themselves:

> The range of services to be offered that presumably were needed by clients, was already determined. First of all, clients required syringes, condoms and information materials, so work should be around handing these supplies to them at NEPs and other points. So when NGOs were asked to write what services were needed, this meant in reality to choose from the services already given. By imposing pre-set services, Alliance acted as a restrictor, and a grave-digger of service provision (046: 310-20).

5.4.3 Defining clients of HIV services: 'old' clients and 'new' clients. Coding clients

Alliance M&E Manual outlines "a single electronic management information system (MIS) of clients of various HIV prevention projects for IDUs, CSWs and MSM, which makes it possible to identify former and present regular clients" (Alliance 2008, p. 33). However, the MEASURE evaluation (2011, p. 23) noted that in Alliance M&E data management, two aspects of service provision were "not fully understood: the 'definition of client', as well as what makes a client eligible to be counted as having received HIV preventive services".

The APMG report described problems with client recruitment, lack of incentive for NGOs to retain clients, as well as lack of attraction in clients to services offered:

> In at least two sites, a successful PDI[84] process led to a large number of new clients being attracted (by the financial incentives of the PDI) but few of these

[84] Peer-Driven-Intervention (PDI) – a method that relies on respondent educating and recruiting peers for services (Matiyash 2012). The method involves recruiting 'seed' workers who get paid for bringing in more people to service. In GF-funded settings, the PDI system allowed for clients to receive services for other clients by presenting their cards.

> were converted into regular clients. In one case at least, the SR seemed to have a deliberate policy of *not wanting PDI clients to become regular users of their services* as this would lead to budget problems and staff being overwhelmed with work. In the other case, it seemed that the services offered were not sufficiently attractive to the new clients to keep them coming back. (APMG 2009, pp. 18-19) [emphasis added]

The Interview Guide asked to define a 'client of HIV prevention services', how to distinguish between a 'new client' and an 'old client,' and how or whether the old clients are retained in the database. The definition of what constituted a 'service' was also sought.

Participants suggested that the definition of 'client' and what constituted a 'service' were linked to reporting by the SyrEx database. Participants' responses suggest two qualifiers that were important to person being registered as a client: frequency of visits, and how many services were received by a client in one visit. In regard to both, there was no uniform view of what counted as a 'service' and who counted as a 'client'. Speaking about the frequency of visits, the minimum number of times a person needed to come to count as a 'client' of HIV services, was one – i.e. the person needed to only come once: "Came once – and got into database. If he was entered into database, so he remains there. Even if he does not come again" (035: 139-141), "once in a lifetime and already covered" (025: 582-83), "To be considered covered – once in a lifetime of a project" (014: 215).

Other suggestions varied from person needing to come twice: "New – the one who came for the second time" (048: 195-197), 'once a month' to 'two or three times per quarter': "permanent client - came once a month - covered once a month and already permanent" (012: 347), "Two or three times per quarter… but some come less [frequently] and are still counted" (028: 190-192).

Participants noted that the duration of NGO projects was important in defining clients. As mentioned in Chapter 4, most NGO grant contracts lasted only for one year. Participants referred to this practice as 'historical', introduced by Alliance: "there are certain requirements of Alliance. Their grant cycle is one year, and they only give money for one year. It has been historically like this" (021: 160-62). Participants reported that at the end of each project (year) the client database

was annulled: “we begin a new year by annulling database” (024: 269). If an NGO had won another grant, they would begin a new database in which every client would be input as ‘new’. Participants suggested a confusion of viewing clients as ‘old’ or ‘new’ was linked to using the SyrEx database: “new project period – means a new client base. Everything gets counted anew. There is a [database] key to close the period” (003: 304-309).

> There is a nuance about these databases. The clients are counted during one project cycle which is one year. The next year, the database is annulled, and if clients come, they are counted as new [clients]. (028: 191-193)

Participants noted that when NGOs receive a new grant, they would be typically visited by both groups of clients – those who knew the NGO before and new ones who just came. Because the database was annulled each year, most clients from the old group were re-counted as new:“The projects are for one year. When the project ends, and new one starts, these people are already new clients. So in reality… we know them, we know their faces, but programme-wise they are counted as new [clients]” (032: 259-263).

Some participants did not see a distinction between the regular and new clients because the way clients were defined, was based on clients’ own words. There was no way to check the information clients provided about themselves:

> Some part of those will be new people, some would come from previous project. Again. If they say they have not attended before and they are new, who can check this? (017: 364-366)

There was no incentive to retain clients in services:

> There are problems with “old” clients. [NGOs] do not want to serve them. There is a tendency now to look for new clients… there are such projects that get paid to find new ones. But old clients also come. So they are re-coded as new clients. They give him a new code – and he passes as new. You cannot throw the person out. (012: 345-356)

Some participants tried to define ‘old’ or ‘permanent’ client (*postoyannyi client*): “Permanent client – the one who is visiting twice a month. As a minimum” (048: 200-202).

Others suggested there was no such thing as 'old clients': "There is no such thing as clients from previous years" (003: 265), "old clients don't exist" (012: 358).

A number of participants reported confusion between counting the number of clients and the number of services, and that higher number of clients reported would increase chances of NGOs to continue receiving funds:

> [Researcher]: How are services counted in NGOs? Who is classified as a client?
>
> [020]: Counted, but all wrong. Why? Because in all our NGOs one and the same client is counted. Why is this needed?
>
> Researcher: May be, he simply wants to get maximum of services in different organisations?
>
> [020]: it's his problem. Such is our mentality. We want to grab here and there, and there. At the same time we say we work in a tandem. By services – we count that we delivered 100,000 but it means in reality that 10.000 people went through services– ten times less. … NGOs blow up statistics in order to participate in project, to receive more money. But there are no norms. NGOs act on their own. So we have few people covered, but with so many services, and money is plenty, so why there is plenty of money, because they are linked to the number of services and not to the client. (020: 114-139)

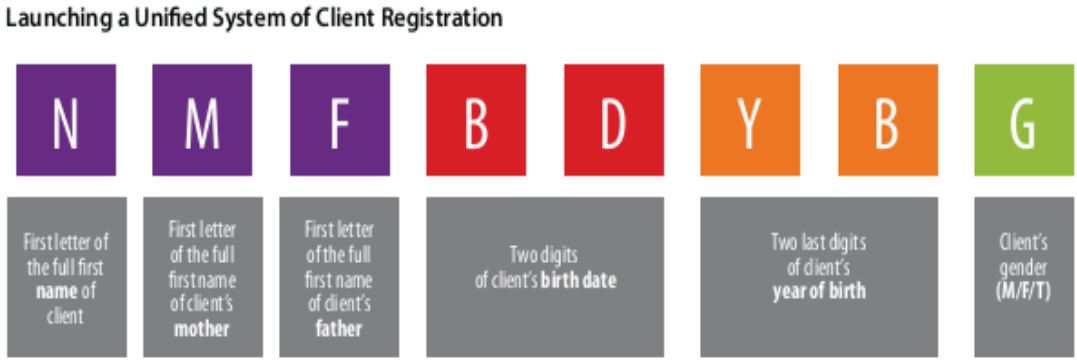
Coding clients

Coding of clients was done during most part of R1 through the SyrEx system. The OIG 2012 report described the basis for assigning the client codes in GF programmes and suggested there was a high variability of coding systems, as a result of which, double counting of clients was possible:

> Client codes are based on personal information in order to be restored easily in case of loss of client card records. [T]he current client coding system used by the Network does not address the risk of double counting by Sub-recipients delivering the same services. Coding systems currently vary from one organization to another. (OIG 2012b, p. 37)

In 2011, the Unified Coding System (UCS) of counting clients was piloted by Alliance, as a measure to avoid data duplication (OIG 2012b) (see Figure 5.4):

Figure 5.3 Launching a Unified System of Client Registration (Alliance 2012, p. 37)



Alliance R6 final report underlined that the implementation of the new Unified Codes reduced the probability of clients' double counting and increased data accuracy. However, the Summary Report on 2011 results, released by Alliance a few months earlier, noted that *"*a client will have an opportunity *to get services in several NGOs simultaneously*",[emphasis added] while "the client's code will be the same in every NGO" (Alliance 2012a, p.4). It remained unclear whether, by documenting multiple use of services by same clients, the new coding system would help to overcome the existing confusion between the number of clients and the number of services, reported above, or contribute to it.

The interviews for this study were conducted at a time when the new coding system was being introduced and this topic generated considerable response.

Participants described the old coding system as based on self-reporting from clients. The staff person then assigned a code to the client based on the information given by client:

> Alliance recommends that organizations create codes themselves. They use family name, patronymic etc. Capital letters. But a smart person would know how to use this system. This should not be coded by a staff person. Coding needs to be assigned automatically. By an automated system. (048: 237-242)

Regarding the new Unified coding, participants suggested that the new system could be open to manipulation because it was also based on information provided from clients' own words. Besides, it did not require clients to show up but only to be registered and have cards:

> A Unique Code system is based on cards. But we detest it..Because information is taken from client's own words.If client said a Unique name – for example – mother's name, date of birth etc – and has been assigned a Unique code, he understood that. Then he went to a different point of delivery – with a slightly changed mother's name – and there he gets a new Unique code. So he takes his new card and leaves. We have clients – drug-store based – who come having ten cards. (017: 367-376)

> Drug users brought registration cards of other drug users. It is convenient for organization to distribute materials to many people to one person at once. It is beneficial to drug users who get multiple supplies at once. But another question – who is behind those cards? (014: 221-224)

Participants also noted the new system did not have a mechanism to capture overlapping clients:

> After the Global Fund requirement – in 2011 – they began introducing a new unified code – to avoid duplication. For example, there is one city in Ukraine that had 14 NGOs that were funded by one PR. So clients were walking around town visiting all these organizations. (028: 196-206)

> The person needs to receive multiple services. Nobody is controlling him – not me not another organization. There is no such mechanism as to control his movements. (006: 230-232)

5.4.4 Some features of reporting culture as perceived by participants

Drew in Trip 6 report underlined a need to build an "*M&E culture* which is focused on collecting essential, high-quality data that is needed to mount an effective response to the epidemic". He outlined a few barriers to this culture: over-reliance on passive case reporting, the norm that meeting targets is more important than reporting accurate data, the view that "measuring more indicators and conducting more surveys is better than doing a few good surveys and measuring a few key indicators well" (Drew 2005d, pp. 5-6).

'A good M&E system', Drew implied, should include rigorous systems for ensuring that data is true, particularly in settings where pressures to present 'on-target' data were high – and under such pressure settings were "all settings where performance-based funding applies and also in cultures where targets were expected to be met or there would be fear of punishment" (Drew 2005d, p. 11). Spicer et al. observed "a culture of fear derived from concerns for personal safety but also risk of

losing donor largesse" that their study identified among the CSO representatives in Ukraine (Spicer et al. 2011, p.1754).

The AMPG report (2009) reviewed monitoring processes in SR NGOs and noted two parallel processes for data gathering –"Official Process" by which social workers first entered the information into their journals, then transferred this information onto the standardized paper forms, and then put it into SyrEx database; and the "Actual Process" by which staff made informal Field Notes for their own use, and then transferred information to official monitoring forms and database (APMG 2009, pp. 23-24). Observations of outreach and other activities found examples of social workers not filling in monitoring forms or spending so much time on the forms he had no time to talk to clients, as well as clients showing up with two or three registration cards and with up to seven PDI cards[85]. The report concluded that "client registration mechanism and existing forms did not prevent double counting of clients" (ibid., p. 24).

Participants noted the internal character of monitoring as a feature of PR data collection: "a lot of Monitoring and Evaluation data published by GF Principal Recipients in Ukraine was generated internally. [T]here was no system in place to check the veracity or validity of those data." (049: 368-371)

Chapter 4 described reaching GF targets as a 'race for figures'. Instances of *pripiski* (add-ons, or double counting) of data on providing services provision were reported by participants as widely spread in GF-funded settings.

In particular, a specific case of *pripiski* was described in R1 in regard to a state Sub-recipient. In this case, coverage data in state services run parallel with the NGO data providing services, while sharing the same clients:

> When harm reduction programmes began, the state services for youth created Trust centres, but the state did not execute these programmes, it could not execute them. They were done by NGOs whose statistics were simply used by state programmes. The same clients were shown twice – in GF programme statistics, and in state statistics on youth services(014: 66-72).

[85] PDI – Peer-driven Intervention, see a footnote on p.266.

Participants described how the process of *pripiski* worked in other GF-settings. *Pripiski* were done at both stages of SR projects:

- At submission: writing a proposal with a 'desired' number of clients – even if organization knew it may not be able to cover them:

  The sum of a grant project depends on the number of clients that project serves. If organization submitted a project to cover 500 clients, but in reality it only has 100 clients – it makes them write in these 400 clients anyway. (028: 174-177)

- At the reporting stage – when reporting the number of services delivered – because under-reporting was discouraged:

  At last, under pressure of facts, it became obvious that there are obvious *pripiski*, which were on the surface denied but … indirectly you see this... the drug scene is closing down, but coverage is growing, funding is reduced – and logically, the coverage of every new client should be more expensive – but it looks cheaper… so when in some projects coverage approached 104% - like in Soviet elections, (smiles) and calculations were even made to show that it was impossible for such a number of clients to pass through a NEP[86] in one day – that was equal the number of people in May Day parade" (046: 276-285).

  If you cannot influence the indicator, you can influence how it is counted… organization puts effort so that indicator becomes like it needs to be. (041: 287-290)

  [*P]ostavit galochku* – means to fill the number of clients planned in target indicators. (041: 492-93)

Participants noted that in order to satisfy the overall PR targets, *pro forma* reporting was taking place. One of reported practices was occurring during supplies disruptions. On such occasions, PR (Alliance) would tell SRs to reduce handing out needles/syringes etc. until the supplies were restored, but show regular hand-outs in reporting: "there were periods when supplies are disrupted. Alliance says – reduce hand-outs to clients. When supplies are restored, more instrumentarium (paraphernalia) should be handed out so that in the overall result it all looks even – as much as was planned, was distributed" (012: 308-315); "Organisations always hold

[86] Needle and Syringe Exchange Point (NEP)

on to some amount of dirty syringes in case of inspection from donor, or in case if monitoring comes" (014: 486-492).

Participants spoke about "mass data falsification by NGOs in Round 6" (042: 351), because PR reporting systems allowed for "multiple comebacks" (019: 601).

Participants also reported that a part of the reporting culture in GF-funded services was a tendency not to include information about unreached targets:

> [Efficiency studies] are conducted, but how they are conducted? We are used to this practice – you always need to report that everything is good. Bad? - nobody would say this about his organisation. Bad – means everybody worked badly. It is deeply rooted. This is a practice [common] in all programmes and projects now. (043: 148-153)

Some participants reported inflation of data on syringe exchange: "reported data is inflated. There are targets that must be met. Funding determines the number of clients to be covered" (014: 159-160); "Majority of syringes were never collected" (012: 492).

A number of participants suggested that 'pretty' prevention targets were set high by PR to GF, and then passed on to local SRs to implement:

> NGOs were scared to do re-programming, even if they saw targets could not be reached, because it cast a cloud on the organisation. Nobody wanted to stick out, and everybody wanted to show pretty indicators, but how to achieve them? If [SR] NGOs would start massively to re-programme their targets and draw them to real figures, then Alliance would have to do the same at the national scale. And they did not want to because they already blew themselves off to GF. (046: 420-428)

Participants also suggested that double counting was resulting from other donors funding the same organisations[87]:

> There is a paradox, but all programmes are the same: GF, UN, SUNRISE. Often there are overlapping activities – this project is handing out syringes, and that project is handing out syringes, these ones attract clients and those attract clients. Often the same clients come. From year to year, the same organizations win grants. So it's not only duplication, but triplication, quadruplication. (012: 273-279)

[87]In Chapter 4, the process of channeling the funding to 'mega' NGOs in high-priority regions was described.

Regarding how wide-spread data inflation practices were, participants suggested that "fictitious reports are compiled by 70% to 80% of all NGOs" (014: 172-173). Others suggested that no information coming from NGO could be verified: "Regarding the third sector, assessment was given to NGOs. In fact, I could give any figure – from the ceiling – and it would pass" (046: 341-345).

5.5 Other issues of access to HIV services

A number of other issues related to accessing HIV prevention services came up in document analysis and in interviews. Semigina (2009) evaluated the overall accessibility of HIV services in Ukraine. In the study, data obtained from service providers and clients suggested different perspectives between providers and clients – "the vast majority of service providers rated their organisation as highly accessible; clients were far more critical about levels of service access, with a high proportion rating a service highly or fairly inaccessible" (Semigina et al. 2008, p. 8). The study noted the interviewees having been recruited through GF-funded organisations, therefore the survey was not able "to elicit the perspectives of individuals not using HIV/AIDS services"(ibid., p. 14), which can be seen as affecting the study's conclusions.

As noted above, access to services in regions had wide variations as diffusion of GF programmes into all geographical locations in Ukraine was not even. Semigina(2009) reported that in R1, most GF funding was disbursed in the six major regions: Kyiv and Kyiv oblast, Odesa, Mykolayiv, Donetsk, Dnipropetrovsk oblasts and Crimea, she also noted that GF-funded programmes tended to be established in areas where USAID programmes already worked. The APMG evaluation noted that "expansion into agrarian regions by SRs has been difficult because of logistical and ideological difficulties and the need for intensive infrastructure investment to reach relatively few clients" (APMG 2009, p. 20).

Participants thought that GF funding was directed mostly into the high priority regions – and in them, mostly into *oblast* centers and large cities- because USAID already funded work there, and infrastructure was relatively well developed:

"USAID policy had important influence over distribution of services in regions" (049: 152-166).

An outcome was, as suggested by participants, that the GF-funded services were not reaching beyond urban areas:

> The problem is that services do not reach to the district level, or level of small towns. (002: 305-315)
>
> ..rural populations are not covered. (010: 140-147)

Regional gaps in the diffusion of HIV services were mapped in several reports. In 2009, Alliance-Ukraine report outlined 'highly affected regions' where most of the Alliance [GF] investment focused (see Figure 6.1):

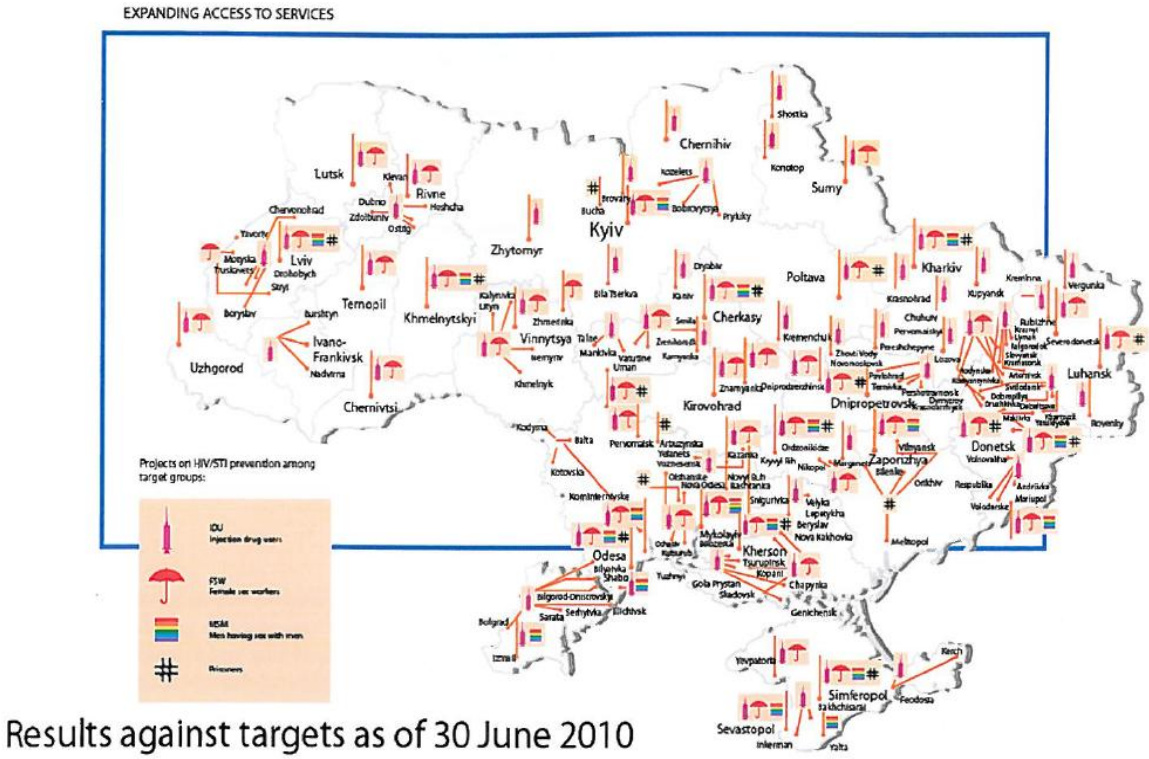
Figure 5.4 Map of Ukraine with services and coverage (Smyrnov 2009)

The map shows that most GF investment focused in the following oblasts: Kyiv, Cherkassy, Dnipropetrovsk, Donetsk, Odesa, Mykolayiv, Kherson and Crimea. It is clearly seen that the numbers of people covered (shown in blue and red inside white boxes) were the highest in these oblasts. In line with findings presented above about the coverage and duplication of services, it is easy to imagine how these large

numbers were generated by regional 'Mega NGOs' located only in a handful of Ukraine's regions, and were then passed on to construct the national coverage data. Because the coverage data reported for Ukraine by PRs to GF was cumulative, in reality coverage was only occurring in a fraction of regions, leaving other regions under-covered or covered irregularly.

A 2010 report had similarly shown an uneven concentration of GF-funded projects in the regions:

Figure 5.5 Projects on HIV/STI prevention among target groups (GFATM, 2010, p. 10)



As seen from the map, multiple projects for all populations targeted by GF were concentrated in Donetsk, Odesa, Kherson, Mykolayiv, Dnipropetrovsk oblasts, while Chernihiv, Zhitomir, Chernivtsi, Uzhgorod, and Lutsk oblasts had few projects, and those only reached one group - drug users.

Lack of research on whether access to GF-funded services was gender-sensitive should be noted. Available documents express concerns regarding whether the GF-funded services were gender-specific. OIG has noted general lack of understanding of the meaning of gender specific client needs (OIG 2012b), while

APMG evaluation noted "systemic lack of understanding around women-specific barriers to services" (APMG 2009, p. 20):

> [T]here was little evidence that gender-specific services were being offered beyond the female sex worker programs, or that staff had basic knowledge around the unique needs of women who use drugs, men who have sex with men or transgendered clients. In most focus groups with staff it was asked if they had any special programming for women or unique services tailored to women and consultants were consistently told that women were treated equally and had the same access to services as men. When asked if women had unique barriers to services, staff seemed confused.

The gender dimension of HIV services was not covered by Interview Guide questions, mainly because it represented a wider scope of analysis that this study objectives were not meant to cover.

Participants spoke about knowing about women-centred initiatives in GF-funded settings, but reported those were not seen as active, opened by PRs:

> You have a network of women with HIV/AIDS… but it's quite inactive because it's just a kind of branch of All-Ukrainian Network (of PLWH). There is probably a gap here... (050: 365-367).

Similarly, there was no documented evidence found that GF-funded services were income-specific. One participant suggested that GF-funded programmes did not distinguish among different drug users and targeting of IDUs was not means-tested:

> It was not known if drug user was rich or poor. Economic criteria were not considered – behaviour was the same, but economic factors not counted. It is important, because drug users differ in how much money they have. Drug user with money has no problem buying syringe [in drugstore], they need to be aware that they should buy it. But for drug user without money – you need to do something… but how to distinguish? It was not done. Only behaviour characteristics were important. (039: 98-105).

Reports mentioned issues of access to services for disabled people. The APMG report noted that:

> A number of community centres and some other services were on the third, fourth or even fifth floor of high-ceilinged buildings so that people who may be ill with HIV disease or have mobility problems would be unlikely to access them easily. Also, though *most clients seemed resigned to having to travel long distances to access NSP* [88] , especially at fixed sites, and community centres, SRs were concerned that they could no longer provide

[88]NSP – Needle and Syringe Programmes.

> transportation assistance to clients and that this would lead to fewer clients accessing NSP and other services. (APMG 2009, p. 21)

Conclusion

It can be summarized that the practices of data inflation, regardless of their scope, can be a litmus test of serious gaps in data processing and cast doubt over the whole coverage data reported by PRs. Lack of unified standards of services and wide deviations in understanding 'clients' of services contribute to this uncertainty, as well as ownership of the data software by one of the PRs. Independent research into this area needs to be continued that would engage a wide range of respondents.

Studies into whether the GF-funded services in Ukraine were gender-sensitive, as well as income-based and disability-sensitive, deserve a special look and represent interesting venues of further research on GF. Lack of understanding of the needs of sub-populations, and 'blindness' to cross-cutting issues such as age, gender and income, may be explained by mostly behavioristic and narrow view on injecting drug users as a homogenous group. Existence of such a view was possible due to externally imposed approaches to HIV prevention that appeared not to be adapted to realities in Ukraine.

CHAPTER 6. CCM IN UKRAINE: A FALLACY OF COUNTRY COORDINATION OR A WORKING GF GOVERNANCE MODEL?

6.1. Country coordination in GF programmes in Ukraine: why study CCM?

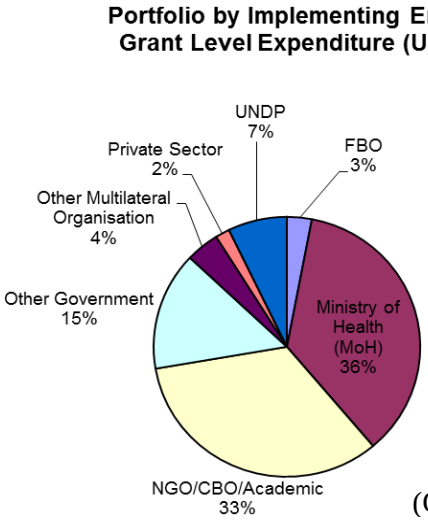
As described in Chapter 1, according to the *country ownership principle*, GFATM does not have in-country presence or representation and relies on a model in which Country Coordinating Mechanisms (CCMs) develop proposals and oversee programmes, PRs receive funding and implement programmes, and a LFA provides in-country monitoring. The CCM is viewed mainly as a model of multi-sectoral coordination, in which different sectors are assumed to play different roles: "While government lends political legitimacy to this partnership, NGOs incorporate the aspirations of the poor and marginalized, and private sector actors contribute a results-oriented work ethic. Development partners bring technical support and financial resources from the international community" (GFATM 2008, p. 9).

The CCM-related governance in GF programmes has only recently began to be researched (Spicer et al 2010). There is evidence suggesting that the CCM membership may be skewed towards organisations implementing GF programmes. The GF High-Level Panel reviewed CCMs that submitted successful applications to the GF from 2002 to 2011. Of the 132 CCMs, 95 percent contained members that were also PRs, SRs or sub-SRs (SSRs) (High-Level Panel 2011). Drew (2004) questioned the general validity of the CCM principle in the FSU states, relating it to the fact that the previous decision-making practice in the region had been (and often remains) much more centralised.

Because of a special importance assigned to CCM to be an embodiment of the country ownership principle, studying how this model manifested itself in Ukraine was an interesting part of this study. By bringing together multiple actors in HIV/AIDS at the country level, CCMs represent a unique venue to observe and understand their roles in decision making, relations between them, as well as decision making mechanisms, policies and practices that are revealed through the CCM functioning in a particular country.

The country coordination needs to be discussed bearing in mind that the 'classical' CCM model, in the way it was introduced by GF as a multi-sectoral mechanism, is typically viewed in context of government-led GF programmes that constitute the majority of the recipients globally(see below):

Figure 6.1 GF Portfolio by Implementing Entity for all Grants in 2005-2010



(GFATM 2011d, p.1)

In such context, the 'classical' CCM is viewed as a platform and a mechanism to mitigate and outbalance the implementing government and ensure that the voices of civil society and communities of people living with the diseases are represented.

In many FSU countries, the GF principal recipients are indeed government institutions (GFATM 2013f). When governments administer the GF grants, under such a configuration, the CCM and recipient government are largely perceived as the same entity, with the level of awareness and knowledge, and mandate sufficient to make decisions over the programme implementation.

Much less has been studied about how CCM model is realised in countries such as Russia, where applications could be made externally on a non-CCM basis (Garmaise, 2012), with PRs being one or several NGOs or, as in the case of Ukraine, an INGO and its Linking Organisation, with unclear mechanisms to ensure the PR accountability to national stakeholders and government. As the monitoring report on Ukraine's adherence to Paris Declaration noted, the NGOs in Ukraine are "not subject to the same controls routinely imposed on the public administration bodies"(OECD 2008, p. 51). The issue in question is what happens when NGOs are

in charge of GF funding and government is not, and how the CCM model would work in such a case.

The specificity of Ukraine's governance context in GF grants was noted by a GF Portfolio Manager during a Stakeholders meeting on 23 September, 2009 in Kyiv who noted that the GF usually signed agreements with state entities in recipient countries that were ministries or government agencies. He described Ukraine's situation as a 'grey field', where grant agreements were signed by GF with two NGOs, and underlined the importance of oversight of the GF programmes that should be within a framework of Ukraine's national law (Stakeholders Meeting 2009).Semigina (2009) argued that Ukraine's HIV/AIDS response was primarily led by two PR NGOs who were unable to influence the larger HIV/AIDS policy but only influenced isolated segments of policy.

Another specific feature of the GF-related governance in Ukraine lay in the way how the PRs positioned themselves on ownership over the GF funding. As noted earlier by Drew, in comparison with the GF globally perceived [PR] role "not as an implementer of programs but rather as a funder of national response", there was a qualitative difference between this perception and how the Alliance as a Principal Recipient was selected to play this role (Drew 2005c, p. 14). Because of the way Alliance was selected by the GF as a Principal Recipient in R1, described in Chapter 2, and the fact that they were conducting R1 programme "in the absence of an agreed national program oversight mechanism" (ibid., p.14), the pattern was established when the PRs could function as distinct entities from government to run the GF programmes in country. Chapter 4 has shown how the PRs positioned themselves and were perceived as donors, funders, rather than implementers of a country-owned programme. This 'donor' role that the PRs have taken on themselves to a large extent determined the way the country coordination mechanisms were to function.

Among other factors affecting governance and country coordination were the 'urgency', 'emergency', and 'short-termism' of GF programmes –an approach that originated from the GF decision to transfer a R1 grant to a grant steward, as argued in Chapter 2. The pressing need to deliver massive GF programmes in a fast-paced environment often precluded the need for a democratic decision making and the need

to agree the decisions with a broader stakeholder community. Instead, as Chapters 4 and 5 have shown, in many aspects of their decision making, the PRs acted opportunistically and practiced unilateral discretion: in target setting for HIV prevention services, in channeling GF funds, in service organization in the regions, and in data reporting practices.

The section below presents a synthesis of document and interview analysis of how the CCM functioned during different stages of R1-R6 grants (2003-2012) in Ukraine, with a closer look into decision-making mechanisms, oversight function of GF programmes, and challenges to HIV governance manifested in the CCM work. This is done with the aim of establishing whether, after the GF Round 1 grant transfer, the CCM in Ukraine has been an effective mechanism of country ownership. In particular, we looked into the following:

- Whether the CCM worked as a national policy making body;
- How it was working – whom it represented, what were the mechanisms of decision making, membership, voting, etc.;
- How the CCM was affecting the relations between various actors involved in GF programmes;
- How the CCM was perceived by various actors; and
- Whether the CCM was an effective coordination structure.

The OIG reports of 2008, 2009 and 2012, the GF High-Level Review (2011), a 2003report on CCM in Ukraine conducted by Prof. Luca Brusati, Roger Drew reports of 2004-2005, various country reports, Ukraine government and the GF documents served as document sources. Memos and notes taken by the author from observing the CCM meetings in Ukraine between 2009 and 2012 and prior to that, were also informing this chapter, in addition to Interview Guide questions through which the main amount of data was generated. The roles and functions of CCM are presented as perceived by study participants based on the interview analysis.

6.2 Evolution of CCM in Ukraine

In Ukraine, a number of national governance mechanisms on HIV/AIDS issues functioned at different times, outlined in Chapter 2. With the first country

submission in 2002and the beginning of the GF activities in Ukraine, a new type of governing body - CCM – emerged that became to be known as *Natsionalna Rada* or *Natsrada* - the National Council on the Issues of HIV/AIDS, Tuberculosis and other socially dangerous diseases. First established in 2002 to comply with the GF submission guidelines, at different times *Natsrada* had assumed different organizational forms, was sometimes dysfunctional or disbanded. Throughout its existence, *Natsrada* reflected more the country's compliance with international obligations and treaties, rather than emerged from previously existing governance mechanisms in HIV/AIDS policy. With terms of reference defining it as a recommendatory, consultative body, whose decisions needed to be further legitimized by different - and upper organs of power – such as President, Cabinet of Ministers, or MOH – it cannot be viewed as a fully governing body.

In general, the CCM history in Ukraine falls into three main periods:

1) *A 'proto' CCM. Beginning of Round 1: application and suspension - from 2002 to January 2004.*

A large, 45-member 'Government Commission on Fighting HIV/AIDS' – *Uryadova Komisiya* - had multiple government ministries and few NGOs represented and was headed by the Deputy Prime-Minister of Ukraine (at the time, Vitaly Seminozhenko). It had a strong mandate as its decisions could be implemented directly and did not require additional government decree. This body has been largely perceived and referred to as the CCM in GF documents and later reports by OIG, UNAIDS, and other donors, based on the fact that it was responsible for consolidation and submission of a country R1 proposal. It needs to be remembered, however, that at the beginning of Round 1 grants – not only in Ukraine – the GF was just beginning to define the very concept of the Country Coordination Mechanism (Brusati 2003), and Ukraine's R1 submission happened before clear CCM guidelines had been developed (Drew, 2004). Brusati (2003) reported that when the R1 was already running and the GF issued CCM Guidelines in June 2003, none of the CCM stakeholders interviewed for his study knew about them as they were not provided by the GF Secretariat. He argued the CCM was proving to be "an important *testing*

ground for Ukraine" (ibid., p. 24). [emphasis added] While the composition and capacity of this 'proto-CCM' could be at odds with the GF implementation processes, and were criticised by a number of NGOs, from the point of view of Ukraine's government decision making, it was a central point and had a high representation of key national decision makers. After the GF 2004 decision to suspend the R1 grant, the Government Commission was disbanded (OIG 2008) and a period of massive government walk-out of AIDS structures ensued. DeBell and Carter (2011)suggest that by putting NGOs in charge of massive grants, the actions of GF have allowed the country to abdicate its national responsibility to develop an operating structure that can co-ordinate the fight against infection transmission. All the subsequent country coordinating mechanisms have functioned with a heavy donor presence.

2) *From May 2005 to July 2007. The second CCM – National Coordinating Council to Fight HIV/AIDS – Natsionalna Rada, or Natsrada - a 'donor-dominated CCM'.*

Its emergence deserves a special look. The second CCM emerged at the end of Phase 1 of R1 and had some of its activities and structures fully or partially funded by donors. Its establishment is linked to the 'Stakeholders meetings'- a *de facto* decision-making mechanism that functioned in Ukraine after the suspension of R1 and Year 1 of Alliance GF Stewardship agreement that ran until 30 September 2005. Drew (2004) called 'Stakeholders Meetings' *by default* the major HIV/AIDS coordination mechanism in Ukraine (emphasis added) and noted 'reluctance' on the side of Alliance during the first stage of R1 to re-establish a CCM:

> [T]here is little appetite for seeking to resurrect a body with the name of CCM in Ukraine. On the contrary, there is a strong feeling that the program is progressing well *in the absence of a formal CCM* (Drew 2004, p. 8)[emphasis added]

As the Stewardship agreement was going closer to the end, no consensus existed between donors and the government on how to build government capacity to resume management of the programme in the future, as envisaged by the stewardship agreement. Drew noted the GF's reluctance to lead, or wait until the change of

government[89], suggesting that a "leadership gap" was created by the GF (Drew 2005c, p. 11). Country governance structures around the GF programme continued to remain non-existent after the appointment of a new government of Julia Tymoshenko in February 2004, while donor-controlled 'Stakeholders Meetings' performed a quasi-governance role. The need for this structure was explained by the fragility of the moment and the need for a "diplomatic approach" with the new government (Drew 2005c, p. 11).

Meanwhile, without settled governance structures, and despite the existence of the new government, on March 21, 2005, the GF sent an invitation letter to submit a request for continued R1 funding to Alliance, the Network of PLWHA, and the Ministry of Health, that had no decision making authority over international matters (Herbert 2005, cited by (Drew and Malkin 2005b, p. 28)). Previously, the GF had communicated on such matters, including the grant suspension, at the level of Deputy Prime Minister. The letter has said: "Due to historical circumstances which have been transparently disclosed by the Global Fund to stakeholders on an ongoing basis, the earlier approved Ukraine proposal is now being implemented under the management of the International HIV/AIDS Alliance as a grant steward."[90] The letter continued that "given the absence of a functioning CCM in Ukraine, the recent election of a new government in Ukraine, … the Global Fund recognizes *the need for flexibility in its grant management and renewal process*".[emphasis added] The application to GF was to be submitted by the 'Consolidation group'(Drew and Malkin 2005b, p.22).The submission process was to be organised around the following timelines:

[89] The 'Orange Revolution' in December 2004 has brought to power allegedly pro-Western President Viktor Yushchenko. More details on Ukraine's political history are provided in Chapter 1.
[90] The GF letter of March 21, 2005 is on file with the author.

	RESPONSIBILITY	TIMELINE
1. Invitation to submit a *Request for Continued Funding*, including *Grant Performance Report*	Global Fund Secretariat	21 March 2005
2. Submission to the Global Fund and the Local Fund Agent of results reflecting progress towards attainment of the coverage indicators **as at 15 April 2005** (*see B.2 below*)	The Alliance	By 13 May 2005 at the latest
3. Submission of the *Request for Continued Funding* to the Global Fund and the Local Fund Agent (*see B.3 below*)	Stakeholder supported 'Consolidation Group'	By 20 May 2005 at the latest
4. Notification to Stakeholder Consolidation Group and Alliance on Grant Renewal Decision	Global Fund Secretariat	10 July 2005

(text reproduced from the letter cited).

The 21 March letter and the timeline show that the GF began to engage directly with its implementers on all matters, including governance issues. The pattern of engaging solely with non-state entities as PRs remained in future GF rounds in Ukraine[91].

After the GF 21 March letter stipulating a submission process by a non-CCM entity (Stakeholder supported 'Consolidation group'), events in Ukraine continued to unroll. On May 17, 2005, just on the eve of the GF submission deadline, the formation of the new National Council on AIDS was announced (Government Portal, 2005), and on the same day the new CCM meeting endorsed the country submission to the GF. The new Grant Agreement acknowledged that "the Alliance was *nominated by a group of stakeholder representatives"* and was "endorsed" by the National Council (GFATM 2005, p.1) [emphasis added]. The OIG noted the decision to nominate Alliance as PR for the new grant was made without a review of its performance, stipulated by the 2004 stewardship agreement (OIG 2008, p. 18).

The new *Natsrada* included Western government representatives as well as some INGOs. It had several sub-committees, whose role was to prepare draft documents and identify issues to be included into the CCM agenda and planning. Its activities, meetings, web-site were supported through the USAID-funded POLICY project which also paid salaries to the Secretariat of *Natsrada*. Notably, the

[91] In R9, Rinat Akhmetov's 'Fund for Development of Ukraine' (FDU), a private foundation established by Ukraine's richest man, billionaire Rinat Akhmetov, from Donetsk, was nominated as a PR for Tuberculosis grant that Ukraine won after an appealing over the GF TRP decision. In Phase 1 of Round 9, the FDU discontinued its PR obligations by a letter to the CCM. On September 15, 2013, GF entered into a R9 extension agreement with the state-run Ukrainian Center for Disease Control.

composition of the CCM showed a diminishing role of the UN family: apart from UNAIDS, all other UN family organisations were only represented by one entity. This was in contrast to previous formats such as UN Theme Group on AIDS and other multi-sectoral bodies that existed in Ukraine earlier. Some of the participants interviewed for this study suggested that the loss of UN leading role in governance structures was associated with the suspension of R1 grant where UNDP was one of the PRs. Earlier, Drew noted that the UNDP suspension made it difficult for other UN agencies to step forward and reported a person from a UN agency as saying, "it is very difficult to act 'if one of your brothers or sisters has been "killed"'(Drew 2005c, p. 4), he also noted that GF did not involve UN agencies in the decision to appoint the Alliance as a grant Steward. The pushing off of UNDP was atypical – in many global settings where the GF operates, in situations that could be viewed as similar to Ukraine's, UNDP manages GF programmes.[92]

At the same time, the 2005-2007 *Natsrada* and its committees had an increased representation of the US government-funded organisations – it included several USAID-funded INGOs, and even an USAID official. For this and other reasons, it had frictions with some government agencies. In 2006, it was challenged by a group of parliamentary deputies who requested the Ministry of Justice (MoJ) to examine the regulations (*polozhennya*) of *Natsrada.*MoJ legal expertise department issued a determination that defined a recommendatory and non-obligatory character of *Natsrada's* resolutions,further confirmed its recommendatory status, and noted that inclusion of foreign government representatives contradicted the legal nature of the National Council as a national governance body (Ministry of Justice, 2006).[93] Harmer et al (2012) described the status of Ukraine's CCM as advisory rather than decision-making body. With another change of government, this *Natsrada* was disbanded and a new one re-instated.

3) July 2007- to present – 'MOH-centred' – This CCM (National Council on TB, HIV, and other Social Diseases) functioned during GF Round 6 and onwards. In 2007, Prime Minister Yanukovych disbanded the 2005 *Natsrada*. The new *Natsrada* was expanded to include issues of TB and other Social Diseases. It has lost most of

[92] In neighboring Belarus, UNDP acts as a GF implementer.
[93] The MoJ legal note is on file with the author.

its sub-committees and USAID funding stopped[94]. The mandate of the *Natsrada* remained strictly recommendatory, with a separate decree needed to issue a policy document. One of the key indicators for assessing the CCM effectiveness was the number of meetings held per year (four meetings) (Yechchenko 2013). Had these meetings been conducted, this would indicate the successful functioning of the *Natsrada*. By a separate decree, a Committee on TB, HIV-infection/AIDS and other social diseases was re-created at MOH[95] that came to perform functions of CCM Secretariat. After a brief *déjà vu* appearance in 2010 of the Deputy Prime Minister Vitaly Seminozhenko[96], CCM functions gradually shifted to MOH. CCM meetings began to be chaired by Ministers of Health (Z.Mytnyk, A.Anischenko), and deputy Ministers of Health (V.Bidnyi, V.Tolstanov).From February to December 2012, the posts of Vice Prime Minister and Minister of Health of Ukrainewere held by Raisa Bohatyriova, later to be replaced by Kostiantyn Hryschenko as a Vice Prime Minister of Ukraine and a Chair of the *Natsrada*.

Shifting of the CCM in the direction of the MOH had implications for broader national governance. With MOH as a focal coordination point for GF funding, it signalled the understanding of HIV narrowly as a medical problem. At the same time, MOH as a health care executive agency, did not have political weight to influence other and more powerful government agencies (Ministry of Finance, Ministry of Interior) over decisions that were important for the GF programmes to be implemented. Lack of understanding of how political systems work in post-Soviet states may explain the persistence with which many aid organisations continuously engage with MOHs.

Apart from the CCM, other structures prominent in decision-making processes during Round 1 and Round 6 grants need to be mentioned:

[94] Following the end of funding, the *Natsrada* web-site with most 2005-2007 documents became inactive. Paper versions of the documents and downloads made earlier, were used for this study.
[95] The previous National HIV/AIDS Committee, briefly re-instated by Yushchenko in 2005 and headed by Valery Ivasyuk, did not gain influence before he was dismissed. More information is provided in Chapter 2.
[96]Seminozhenko headed the first 'proto-CCM' in 2003. In 2010, he was appointed a Deputy Prime Minister and a new Head of the National Council. At a CCM meeting on April 20, 2010, he pledged to scale-up government leadership in HIV/AIDS. The post of the Deputy Prime Minister was abolished in 2011.

1) HIV Stakeholders meetings – were held as parallel forums to government-centred decision making bodies and included mostly NGOs, INGOs, and donor organisations, including UNAIDS. Drew suggested that early rivalries and group interests were already present among donors in relation to GF programmes, however, he also noted that coordination with other programmes was "not an explicit and central part of [Alliance's] terms of reference" (Drew 2005c, p. 8), suggesting the high level of PR discretion in decision making regardless of other donors. Apart from 2004-2005 period when they were 'by default' a decision-making mechanism in Ukraine, in other time 'Stakeholders Meetings' continued to be dominated by PRs and were an important venue for influencing the way the GF programmes were run. A typical feature of 'Stakeholders Meetings' was holding them on the week, or several days preceding the date of the *Natsrada*, and then announcing a stakeholder resolution/recommendation on the day when *Natsrada* was to consider its own agenda agreed weeks in advance. Because recommendations coming from stakeholders meetings were often linked to donor funding, such practices were essentially 'setting the stage' for the CCM.

2) *Stakeholder-supported 'Consolidation Group'* (*soglasitelnaya gruppa)*– was established during R1 transfer to mitigate various conflict of interests around GF programme, and to draft decisions for the National Council, or for Stakeholders Meetings. Membership included: two PRs representatives, one Ukrainian NGO representative, a UNAIDS representative, a USAID representative. Drew noted, in relation to 'Consolidation group' in R1, "the added problem of lacking in-country legitimacy since NCC [CCM] was established", as well as having "no jurisdiction over funds provided through other programmes (Drew 2005e, p. 34). During R6, the tradition of having a 'Conciliatory Group' continued, and it was reviewing PRs grant performance reports. OIG called it as "a forum for the resolution of disputes between the PRs and sub-recipients", questioned the Group's legitimacy as having "no provision for such a group" in the GF grant architecture and described the 'Conciliatory Group's functions as "typical functions of the CCM". OIG also recommended to CCM "to adopt a more proactive role in overseeing grant implementation" (OIG 2012b, p. 52).

3) *Oversight Commission* (*Komisiya z naglyadu*). Throughout all R1, and for the most time during R6, Ukrainian CCM did not have a functioning oversight mechanism. Finally established by CCM on 17 August, 2010, this body was aimed to become a CCM tool for overseeing the GF programmes implementation. Its composition largely included people who were already members of the CCM. OIG has analysed country oversight mechanisms of GF programmes in several countries, including Ukraine, and found the level of oversight to be weak as characterised by failure by the CCM to identify and rectify key issues that affected GF programmes. OIG report characterized oversight by CCMs "*at best* by PRs reporting to the CCMs" and noted that CCMs did not have mechanisms to verify and monitor the performance/results reported by PRs (OIG 2009, pp. 26).

Oversight Commission acquired prominence in March-April 2012, after the release of the first draft of OIG audit, when it led the work to prepare a consolidated country response on OIG audit recommendations but faced challenges from the PRs who demanded that it should verify the accuracy of OIG findings many of which were critical [97]. Members of the Oversight Commission periodically conduct monitoring visits to different GF-funded venues, but, apart from those, similar to CCM, the Commission does not have other mechanisms or instruments to verify and/or monitor the PRs performance/results. Besides, its members work on an unpaid basis and there are no state funds provided to support its work. There is a provision in the Commission's *Polozhennya* (Terms of reference) that the organizational, methodology, technical, information and logistic support of the Oversight Commission is the responsibility of the National Council Secretariat with assistance from international and donor organizations (National Council, 2010) that allows it to receive funding, for conducting meetings, travel expenses and modest honoraria. Because the money comes in external grants, this puts the Commission in dependent position from donors and too close to CCM Secretariat, which compromises its

[97] CCM meeting on March 29, 2012, attended by the author, discussed a draft OIG report of PR performance (Natsionalna Rada 2012). The report contained over 50 'High Priority' criticisms of both PRs systems and performance. PRs were challenging the report findings as inaccurate and OIG for publicizing the draft, while the head of Oversight Commission stressed the absence of monitoring instruments to verify the audit findings. The official version of OIG report, released in August 2012, signed by the GF Manager General Jaramillo, said that most findings have already been addressed by PRs.

impartiality role as an independent mechanism of overseeing that GF programmes are implemented in accordance with national ownership principles. There is no provision to rectify situations when members of the Commission may have different opinions over PR performance or results. Decisions are taken by a majority vote, and thus, according to *Polozhennya,* the number of Commission members cannot exceed seven people (National Council, 2010). Another provision stipulates the Commission to conduct its oversight activities at the CCM request, which means that in absence of such request, or when CCM is not meeting, Commission becomes inactive.

6.3 Participants' perceptions of the Country Coordinating Mechanism

6.3.1 CCM functions and roles as perceived by participants

The questions in the Interview Guide were asking participants about the effectiveness of the National Council. 'CCM' and 'CCM effectiveness' emerged as the themes from the interview analysis. The main sub-themes in relation to CCM as perceived by participants, were 'formalism', 'lack of effective coordination', 'geared to GF', 'artificial structure', 'PR tokenism', 'PR instrument', as well as other features that are presented below.

How CCM worked – membership, representation, mechanisms of decision making

Uniformly, participants noted that CCM was created at the impetus from external donors: "CCM creation was under significant influence of international donor community" (002: 609-610). As such, it functioned as a mechanism "to attract external funding" (001: 381-85).

Participants noted a formalistic, *pro forma* function as a common feature of Ukraine's CCM:

> CCM is an absolutely formal structure. It is such a room for voting. Because the assumption is that people who come there already made decisions, so they come there and unanimously vote... all decisions that need to be taken by CCM are taken by different mechanisms and in other places. (028: 355-365)

Many participants linked this formalistic role to the fact that CCM was a GF requirement, it was"more of the performance of compliance with the Fund, rather than particularly meaningful" (046: 308-310); "… a requirement of the Fund. It was very much set up by GF grants and securing the grant in mind. But beyond that, not an active structure. Its oversight function seemed to be much weaker than its purpose to put together a GF proposal" (049:279-286).

According to participants, CCM mandate over GF funding was weak because it did not have any formal agreement with GF: "CCM does not have power over GF money because grant agreement is signed between the GF and PR" (026: 303-304); "Natsrada cannot much influence GF programmes. They have no control over money, nobody respects them, and they really badly orientated in what needs to be done" (012: 370-373)

> [I]t is a recommendatory-consultative body. If Natsrada does not agree on some issues between themselves, its members cannot influence PR reports to GF. Yes, they can express emotions, advise something, but in terms of decision making, no, they cannot influence anything by saying we won't sign or something. They don't have such mandate. (038: 300-312)

Some participants suggested that CCM was not a "typical body of state governance" (036: 270) and could not influence state policy: "this CCM is really toothless… they were taking some decisions there regarding GF money – but they could not influence state policy, policy of MOH" (015: 347-350); "a quasi-executive body – not enough mandate, not a full body of power" (044: 224-25).

CCM only heard what was reported, did not make real decisions and did not have real power: "After R1 grant transfer, CCM did not have any legal power to influence national AIDS policy" (015:343-345), "CCM decisions are not mandatory" (044:217), "no influence on PRs" (044: 259-260)

Being a weak structure, CCM "... cannot execute decisions, and is harmful to GF interests in the long term" (041: 262-63)

Some participants thought that CCM was more biased towards AIDS issues than other infectious diseases under its scope.

Participants gave accounts about how CCM meetings were conducted:

> On the day of the CCM meeting, small PR reports are handed out. Then PR directors come out and read their reports. Some members of CCM, deputies ask – how can we accept your report after a five minute talk and a small handout when it requires analysing the targets, the means spent on reaching them, and who participated? – all this requires a thorough preparation. There were times when some deputies walked out of the meeting, calling it a 'shambolic business' (*sharazhkina kontora*). After that they were accused [by PRs] that it's is none of their business as PRs signed an agreement with GF, and state has no right to determine what they report and how they spend the money. Then a state official asked: "If you don't need our input, and decide everything, why do you need to come here and report to us?" (013: 382-392)

> It's so Sovietique. If you go there, it's in Ministry of Health, and there is this table (presidium) set above the rest of the room. And just how it is happening... It's not effective, it is not taking the right decisions because the situation is not changing. (050: 257-262)

Participants described the voting systems. In particular, they spoke that the typical voting pattern at CCM was based on a majority vote and that consensual decisions were not sought:

> Decisions are never made by consensus. Only by majority of votes present. Even when there are some people against continuation of funding, the decision is made in favour, because those in favour are in majority. But there is no consensus and it is not sought. (026: 279-282)

It was also possible for CCM members to vote by proxy. This practice, according to participants was common. Participants reported a case when one member represented eight other CCM members by a proxy vote. Other cases included, e.g. when "the decision was already made, and CCM members were not present, the [secretariat] were travelling to them to collect their signatures" (025:190-94).

Some participants also suggested that that practice for CCM was not to be a place to hold a debate and that all decisions should have been agreed in advance:

> Ukraine had different heads of CCM, regardless whether they were more or less authoritarian, they all wanted the debates to settle before the [CCM] meeting... because it [CCM] was not a 'Shuster-Life' show[98]. So all

[98]A popular political TV talk-show that invited politicians, experts and journalists to discuss current issues.

> stakeholders were to meet separately and reach agreement, argue somewhere... so when the meeting took place, the draft decision was already prepared. You could add something minor, like technical issue here or there, but the core of the question would not change... PRs influenced the preparation of draft decision, worked with [CCM] Secretariat closely. (025: 336-356)

6.3.2 CCM - a venue manifesting the relations between various actors in GF programmes

Participants strongly reflected on the CCM being 'a PR instrument', oriented at, or controlled by from PRs:

> National Council, especially on early stages of GF, acted as an attachment of PRs. It was only needed for GF to continue funding its projects. It was de jure state body, but it did not function as a state body. They met once in three months, or once in 6 months. Some intervals were up to one year. And they only met to vote a new funding request by PRs. (026: 227-239)

> CCM is a convenient instrument – for PRs. It meets when they need it, passes the decisions they need. And does not do much beyond that.(013: 246-252)

Within CCM, there is mostly representation of vested interests of organisations linked to PRs: "PRs and international organisations that work closely with PRs– have leadership in CCM and .. manipulate the decisions it is taking. (014: 254-55)

Meanwhile, CCM members do not have a full understanding of GF programmes: "CCM do not have time or the will to learn how GF programmes are going in Ukraine" (045: 522-24):

> Government did not articulate its position often. Government officials did not understand these [GF] programmes... there is often change of government..a new team gets in, there is simply human capacity lacking. One person was trained, but then he leaves, and a new guy comes in, train again. (025: 202-207)

PRs were not accountable to CCM: "none of PRs is accountable to CCM, but only to the GF" (044: 243-45).

Some participants called multi-sectoral collaboration as 'state consumerism': "consumerism by state organs of free-of-charge aid – this is what multi-sector collaboration is like" (044: 209-213). State officials viewed GF money "as additional

resources that need to be attracted. They are interested in money, but they cannot determine policy" (012: 134-137).

6.3.3 Perceptions of the CCM by participants

Participants described CCM as:

- a place for hearing PR reports: " It was a venue for PRs to read their reports" (013:292).
- as 'organ of zero coordination'
- as Soviet-style, 'quazi' democratic mechanism of decision making, "window dressing structure" (044: 238); 'masquerade'-like structure to mock democratic mechanisms:

  I think it's not effective. It's a kind of masquerade – and the people who are there ... they already agreed on everything...[O]ther people who can comeare either under influence of these people or too shy to speak. There are few people who participate and can say openly what they think. I don't see any strength about this CCM. It's so Soviet. (050: 253-257)

- as a structure with no country ownership:

  There were quite a lot of Coordinating and decision-making structures in place. Main comment was on the balance between the need to do something very quickly to tackle on important health issue and in doing that, compromising the means - so that NGOs controversially deliver or manage services that are seen as eroding country ownership – and possibly, not strengthening, or even weakening country health systems in different ways. (049: 472-78)

Participants suggested that government only "tolerated CCM because of image-making concerns. Ukraine wants to look good to foreign donors. Often decisions are made out of thinking about the country image abroad. It's an image thing... for a government official it is important" (025: 358-364).

In participants view, *Natsrada* functioned as a 'mock' governance body. Heavily dominated by donor organisations and PRs and their partnered stakeholders, it was not functioning in a way that typical governance structures function in Ukraine.

Natsrada had no effective oversight mechanisms to review GF grants performance. The Oversight Commission was only established following GF recommendations, and late into R6 implementation. During R1, there was no national oversight of GF programmes. *Natsrada* had few or none performance evaluation mechanisms of its own work. The terms of reference provided to hold a certain number of CCM meetings per year as an indicator of its effectiveness.

Notably, many of the Global Fund own decisions were made in absence of *Natsrada* or without being endorsed by it, among them:

1) The decision to suspend the Round 1 grant and transfer the funding to INGO.

2) Re-programming of R1 programme from treatment-oriented into prevention-oriented.

Conclusion

CCM model of country ownership in Ukraine has enabled a functionally impaired governance structure without a genuine decision making power over the GF funding. As reported by study participants, during R1 and R6, the *Natsrada* (National Council to Fight HIV/AIDS and TB) functioned mainly as a *pro forma* structure to fulfil the GF eligibility criteria during the country submission and as a venue for formal endorsement of periodical GF grant disbursement requests. *Natsrada* decisions were not mandatory, and it could not alter or re-programme GF funding. Voting and attendance could be by proxy, consensus was not sought, and a majority vote was taken as a decision making mechanism.

It can be concluded based on the material reviewed and interview analysis that Ukraine's CCM functioned not as a genuine country ownership mechanism but as a 'mock', 'quasi' governance body, whose agenda and decision making were influenced by PRs and a narrow group of stakeholders, and it did not execute effective country-based programming and oversight of GF programmes.

CHAPTER 7: DISCUSSION

This thesis presents findings of the critical ethnographic enquiry that examined the Global Fund's aid delivery model in the context of Ukraine. Delivery of HIV prevention services during the GF R1 and R6 grants (2003-2012) was used to analyze how effectively NGO Principal Recipients in Ukraine promoted and implemented the GF core principles, service delivery and governance models, the systems and practices they created, and the adequacy of GF oversight systems over the GF funding.

Chapter 1 provides a thematic background to the concept of aid effectiveness. Its overview of the evolving concepts of aid delivery during the 20th century established the ramifications of the subsequent strongly critical debate about traditional aid institutions and models of aid delivery, which developed after WWII (articulated by Bauer 1975, Easterly 2003, Friedman 1995, Knack 2001, Moyo 2009, Prokopijevic 2006, Svensson 2000, and Williamson 2009). The vigorous debate led to efforts to articulate aid effectiveness and harmonization principles, reflected in the GF delivery model and embedded in the Paris 2005 Declaration. Both the GF and Paris Declaration were a response to aid critics and were intended to resolve the worst problems of multiple donors and externally driven agendas. The GF, in particular, emerged as a response and a reflection of its backers' belief that a new approach was needed, one that could operate more effectively than existing bilateral and multilateral aid mechanisms (Wigell 2008). The research data presented in this thesis supports the critical perspectives within the aid effectiveness debate and demonstrate their continuing relevance in the context of GF-aided delivery of HIV services in post-communist Ukraine.

The G8 Genoa Summit Communiqué (G8 Genoa 2001) that confirmed the establishment of the GF, specifically outlined how the new Fund would work differently to meet the criticisms leveled at traditional donor programming models in the aid effectiveness debate. The pledges made at the GF establishment were developed into research objectives for this study.

In particular, this study has closely examined the following GF founding principles that were intended to address criticism of traditional aid delivery, as they were expressed in the G8 Genoa Summit Communiqué:

- "approach emphasising prevention in a continuum of treatment and care";
- "light governance " and "ensuring ownership";
- "a strong focus on outcomes";
- "local partners, including NGOs, will be instrumental" (G8 Genoa 2001).

In this thesis I have argued that, drawing on the available evidence, the GF core models, delivery systems and governance mechanisms were used opportunistically by Principal Recipients in delivering the GF programmes in Ukraine. It can be argued that, in channelling the aid in Ukraine, the GF alongside with other donors in FSU, has struggled to overcome the legacies of communism, when, in aid delivery, following the traditional aid programmes, they encountered complex systems of patronage and social relations (Bruno 1998; Wedel 2001). The GF choice of an INGO to implement its programmes demonstrated a continuing preference for external organizations and approaches. In doing this, the GF appeared to follow traditional aid institutions' 'external project' method as a predominant form of aid delivery in FSU (Carothers 1999b), that tended to restrict funding to fairly narrow groups in capital cities (Hann 1998). The observed results in Ukraine are consistent with the critiques of Sampson (2003), and Hrycak (2007) that 'external projects' sideline *bona fide* grass roots organisations and implant 'transnational advocates' – INGOs with pre-set external agendas.

While the GF programmes' value was acknowledged by interviewees, perceptions varied of the adequacy of linkages between GF-funded HIV prevention services and state health care, questioned in Chapter 4, as well as GF programmes' effectiveness in the regions as noted in Chapter 5. The outcomes described below in this chapter suggest that GF programmes in Ukraine in fact are subject to the same aid effectiveness critiques that the GF institutional model was intended to avoid.

Ethnographic enquiry, as detailed in chapter 3, was selected as the method for this research because of its ability to enable a 'critical space' and a critical lens to

look into the GF aid delivery model. The ethnographic enquiry undertaken in this thesis incorporated the views of a wide spectrum of the study participants, many of whom participated in service delivery, and integrated other evidence leading to the findings set out in Chapters 4, 5 and 6 above. The robust evidence emerging from the data analysis raises the following issues:

- Based on external approaches to HIV prevention, promoted as 'international best practices', as reported by participants and reflected in the literature, the PR NGOs-run programmes appeared not to have been integrated with the state health care system, but were run in a 'standalone', isolationist manner, with unclear and badly defined referral protocols into the HIV continuum of treatment and care services. This ran contrary to donor pledges outlined in the Paris Declaration that stressed the importance for donors of "using a country's own institutions and systems" (OECD 2005, p. 4).
- It is argued that a Country Coordination Mechanism (CCM) has been used narrowly and opportunistically by PR NGOs to promote their own interests and goals linked to the GF programme implementation. Available evidence suggests that CCM was dominated by PR NGOs, with oversight mechanisms non-existent for most of the period of R1-R6 grants. GF aid programmes were implemented through a network of Sub-Recipient NGOs, whose systems, policies, and practices were not aligned with state health care systems and practices. This had an adverse impact on national ownership of HIV prevention programmes in Ukraine that the CCM was supposed to ensure. This unfavourable outcome of GF-funded programmes has strong associations with criticisms like those of Radelet (2004) that traditional aid programmes relied on a non-adapted, one-size-fits-all approach for all recipients, regardless of the quality of their governance, as discussed in Chapter 1. The reliance on a one-size-fits-all approach in aid delivery in post-communist countries, noted by Carothers (1999b), was manifested in the 'external project method' as a predominant form of aid delivery in the FSU, with little attention paid to local contexts. This research shows how lack of effective oversight and governance through a strong, inclusive CCM resulted in GF-funded PRs implementing HIV prevention programmes that bypassed

the national health systems. As the result, HIV prevention is not owned by Ukraine, and GF-funded programmes are, in their present state, unsustainable.

- In particular, PR opportunism appears to be strongly manifested in the monitoring systems they built to respond to the GF 'performance-based funding' model (GFATM 2009). Document analysis identified concerns about "a lack of national ownership in M&E data collection of HIV programmes and activities" (UNAIDS 2009, p. 26) and data collection "driven by external reporting requirements..., rather than by the national and local information needs of service providers, programme managers and policy-makers" (ibid., p.26). These concerns were further confirmed by analysis of the interviews. As discussed in Chapter 5, participants described the PR monitoring systems as being under 'full PR control'. The target setting and monitoring systems, and the way they were run by PRs, established a cycle through which PRs exercised a high degree of discretion in determining targets, implementing HIV services, and monitoring themselves.
- Based on the available evidence, another unanticipated outcome of the GF programme transfer to an INGO and its linking organisations was to impair the advocacy potential of Ukraine's 'Third sector'. In Chapter 4, conceptualisations in the literature of rich-country NGOs operating as 'donors' with respect to local NGOs and even to states in poor countries (Engberg-Pedersen 2008, p.1), were applied to analyze the impact of the GF decision on "using well-established international NGOs rather than local organizations" (UNAIDS ASAP 2009, p. 44) to implement its programme. This GF decision, as predicted in the UNAIDS paper, "hindered opportunities to strengthen the [local organizations] capacity" (ibid.). Analysis of interviews confirmed weakening of the NGO sector in Ukraine after the GF programme was transferred to an INGO, as discussed in Chapter 4. Participants reported that local NGOs were forced to compete with each other and turned into passive recipients of GF sub-grants, with a limited ability to advocate for issues beyond the scope of GF programmes. A particularly disturbing outcome was the hybridisation of the 'Third sector', manifested in

the appearance of ‘quasi’ NGOs run by AIDS center doctors and state officials to apply for GF and other donor grants, reported in the literature (Spicer et al. 2011b) and interviews.

The following sections of this chapter present more detailed support for each of these issues.

7.1 ‘Standalone’ NGO-run services, not linked to state health care

As noted in Chapter 1, the Paris Declaration stressed the importance for donors of “using a country’s own institutions and systems” (OECD 2005, p. 4).

The GF in its founding principles committed to “pursue an integrated and balanced approach covering prevention, treatment, and care and support” (GFATM 2001, p. 1). In Ukraine, the GF-supported programmes were to “contribute to the implementation of the majority of tasks included in the Ukrainian National HIV/AIDS Prevention, Treatment and Support Program” (OIG 2012, p. 3) and were thus expected to contribute to national health care delivery.

Analysis began with a review of the process and the outcomes of the GF 2004 decision to suspend funding for a government-run programme and transfer it to an international NGO, the International HIV/AIDS Alliance, described in Chapter 2. An anticipated outcome of the GF decision to transfer implementation to an INGO was robust and effective delivery of HIV services. This expectation was rooted in GF’s perception of civil society organizations as “essential, successful and high-performing implementers of Global Fund grants and that direct financing to civil society PRs can improve the speed of finance and add additional capacity” (GFATM, 2007). Within this prism, the central role for civil society organisations was viewed as providing services in the place of weak, scattered, or even non-existent state health care services, typical in many world settings where HIV epidemics ravage societies. In Ukraine, juxtaposition of NGOs to the state, frequently articulated by GF and its PR NGOs, promoted “the image of an international goodness in saving lives in a post-Soviet region as opposed to the image of the impotent post-Soviet state which put those lives at risk, not being able to protect them in the face of the epidemic” (Zhukova 2013, p. 249).

In the FSU health care context, this role did not make sense for several reasons. First, there was already in place a well-established state health care system that included specialized tertiary AIDS health care, described in Chapter 2. Second, NGOs were not perceived as service providers, but primarily as public advocates in post-Soviet states where the public sector was the only one "to provide services needed to the fullest extent" (UNAIDS 2007, p. 39). Finally, there was no legal framework to provide for any external agency other than state-licensed medical professionals to act as health care providers. In the HIV/AIDS sector in particular, health services delivery is an exclusive prerogative and a legal obligation of the state health care system. Thus, Ukraine's original GF country programme, designed to interface with the state health care system, faced serious challenges, when it was transferred to an INGO. This study did not find any evidence that the GF considered the risks posed to programme effectiveness by transferring implementation responsibilities to an INGO.

This study confirms that the original country programme was significantly altered after the GF pulled Round 1 funding from the government implementers and transferred it to an INGO known to promote more narrow HIV prevention approaches, and with pre-existing links to elements of Ukraine's health sector and a group of NGOs, with a harm reduction focus. Adoption of harm reduction programmes (HR) as a condition for receiving all subsequent GF funding began to be strongly articulated during R6. This was an externally imposed requirement that was not present in original R1 country-driven negotiations over the GF programme in Ukraine, which included prevention services to the general population, as well as to groups most-at-risk.

As discussed in Chapter 2, R1 and especially R6 programmes in Ukraine became the largest GF-funded HR programmes in EECA, and among the largest in the world. The programmes were developed on the background of negative perceptions of HR in FSU countries as an external, 'Western concept' (Tkatchenko-Schmidt et al., 2007) and were subject to legal and political barriers to HR in FSU, noted in the literature (Rhodes et al. 2006; Rhodes et al. 2010; Strathdee 2010 et al.). Drew (2005e, p. 30) noted with respect to Ukraine that it was difficult "to determine

whether or not the [GF-funded] programme as implemented has stayed in line with the originally-proposed harm reduction strategies because it is far from clear what those were".

Analysis of interviews revealed similar perceptions of GF-funded HIV prevention programmes as based on external concepts and not based on clear standards. The majority of the study participants reported re-programming of HIV prevention by PRs to a more narrow HR focus in R1 and noted that it turned Ukraine into an 'experimentation base' for politically-sensitive external approaches.

At the same time, participants noted that despite a declared PR focus on harm reduction, their GF-funded 'basic services package' did not provide a holistic HR approach, but consumed large amounts of money on syringe exchange, condom distribution, and some other outreach activities. Needle exchange was constantly hampered by legal issues that were not resolved during R1-R6. Some participants reported that needle exchange mostly halted in 2010 in all regions.

The definition of a 'basic services package' remained fluid throughout the whole duration of R1-R6 grants, with no benchmark level set at any time. Analysis of the documentary evidence and interviews suggests that the HIV prevention service package was *ad hoc*, not based on a consistent standard, and often meant different things at different times. Variations in the HIV services packages provided were reported by participants between regions, between NGOs, and between services provided for different populations. There was no 'mean' or 'average' package of services. Even the definition of 'client' was vague, and both old and new client coding systems had reported drawbacks allowing for misreporting of services delivered.

NGO delivery distorted health care system roles. Participants' responses indicate that the GF-funded interventions were not integrated with state health care services. A "broken link in the chain of services" (WHO 2013, p. 5) between GF-funded NGO outreach activities and entry into the HIV state care system was noted in documents and reported in interviews. Monitoring of GF-funded services focused on simplistic indicators of *polevye* (field-based, outreach) activities, primarily

deliveries of commodities such as syringes, condoms and information brochures, as well as preliminary, rapid HIV screening tests.

Participants reported NGO referral systems varied in NGO settings and were mostly *ad hoc* with no referral protocol or coordination to track who provided what services to mutual clients. Service providers had limited understanding of what constituted an effective referral, reflected in their responses to interview questions. The result was inadequate referral practices between NGOs and state, with no traceable follow-up for a confirmatory screening with state AIDS centers and registration into ART and other services. Lack of effective referral meant fewer patients could enter the HIV care continuum, receive ART and other health entitlements for which they were eligible.

Although in some regions, the numbers of PLWHA were reported as passing from outreach programmes to state health institutions, this appeared to be the result of a particular NGO and individual provider's initiative, and not the result of a formal, institutionalized referral system. In other reported instances, the number of HIV-positive individuals identified through rapid tests screening by NGOs was greater than the local state AIDS centre could receive ('over-referral'). When that happened, access to HIV confirmatory screening was rationed with coupons.

GF funding allocations distributed competitively through PR grants to regional Sub-Recipient NGOs, lacked predictability. Numbers of clients that SR NGOs could serve were not aligned with the local AIDS centers capacity or regional budgets. It impeded the ability of the state sector to plan its capacity to receive more NGO-diagnosed PLWHAs, and to link people with known HIV status to state-guaranteed care entitlements.

Both 'under-referral' and 'over-referral' are detrimental to efforts to reduce HIV transmission. Members of high-risk, stigmatised populations, who may have 'surfaced' once with a positive HIV diagnosis by an NGO, but not linked to state care because of lack of capacity, were at risk of being lost to care.

The urgent need to balance the numbers of PLWHAs identified by NGOs with the ability of AIDS centres to link them to care requires an effective strategy of NGO-to-state referral, and a greater role for regional governments in programming

GF funding based on local capacity. There is no evidence these issues were adequately addressed by PRs in R1-R6. NGOs swollen with massive grants and state clinics nursing small and often shrinking state funds were left to resolve referral issues on their own.

Outcomes:

- The role distortion between state health care providers and NGOs in provision of health services resulted in an accountability gap. The NGOs receiving massive GF funding were not legally obligated to bring clients into care, while government providers had an obligation to provide care but did not have the funding, as reported by participants. As a result, the state health care delivery system, with its focus on AIDS centres, was compromised by unclear referral between GF-funded NGOs and state services. The result was many gaps in the process of finding, linking and retaining PLWHA in the state-centred HIV care continuum. Lack of effective NGO-to-state referral and imbalance of funding allocations in the regions contradict the pledges made by GF in its founding principles that in delivering aid, the GF programmes will "pursue an integrated and balanced approach covering prevention, treatment, and care and support" (GFATM 2001, p. 1).

- By promoting perceptions of the HIV epidemic as concentrated only in some populations, and narrowly focusing HIV prevention programs on high-risk populations, PR NGOs contributed to HIV being seen mostly as a problem of 'risk groups' by society and distorted perception of the risks of HIV in the general population.

7.2 'Soviet style','mock' governance structures

As discussed in Chapter 1, 'country ownership' is a GF founding principle (GFATM. 2001). The Country Coordinating Mechanism (CCM) is at the core of the GF model of governance to ensure that principle in practice. GF guidelines encourage CCMs "to be broadly representative of all national stakeholders"

(GFATM 2005, p. 3) by creating a forum that includes national and international private actors such as local and international NGOs in addition to government (Walker 2011). The GF has itself acknowledged absence of a "shared perception – inside or outside the Global Fund" – about what the 'country ownership' means in practice (High-Level Panel 2011, p.9).

The available documentary evidence as well as analysis of interviews indicate that the GF R1 transfer, re-programming of the original R1 programme, and the delivery of HIV programmes by PR NGOs for most time of the R1-R6 GF grants all took place in the absence of an effective CCM. Stakeholder Meetings, dominated by PRs and external donors, functioned as a *de facto* country coordination mechanism, as documented in more detail in Chapters 2 and 6.

It can be argued, following suggestions in some studies, that transfer of the GF R1 grant an INGO changed the perception of the PR in Ukraine, as compared with the how GF PRs are perceived globally. Instead of being seen as an implementer of GF programs, the PR [Alliance] began to be perceived "rather as a funder of national response" (Drew 2005c, p. 14). This 'funder', donor-like role was confirmed in participants' interviews, where the PRs were described variously as 'money distributors', 'grant administrators', 'business structures' and 'monopolies'. One of the outcomes of the R1 transfer was a complete government withdrawal from CCM, which subsequently disbanded, signalling a possible loss of national ownership over the GF programmes. The lack of transparency or a public mandate over decisions about GF funding remained a characteristic feature of Ukraine's CCM after it re-emerged in later GF rounds. It was characterized by participants as a weak and tokenistic '*Soviet-style'* discussion forum with wide-spread use of proxy voting. Unable to influence or re-programme GF funding, the CCM was a passive recipient of PR reports, incapable of implementing effective oversight structures and monitoring instruments over GF programmes.

Chapter 1 discussed GF challenges to conform to its own governance model and documented suggestions of serious accountability gaps at its Geneva headquarters. GF board members were quoted as saying 'the Global Fund is accountable only to donor states', with donors perceived as having 'an effective veto

power'.(Brown, G. 2007) The GF governance challenges were passed on at the country level and created a governance deficit in Ukraine. A lack of transparency and highly discretionary decision making at the GF Secretariat were reported in the literature discussed in Chapter 1. The GF did not substantively address issues raised by its own OIG, including in his reports on Ukraine (OIG 2008, OIG 2012) about how GF funds were being spent. Rather, GF engaged in conflict with its own OIG, which prompted an infamous crisis in 2011, after which, the GF redefined and narrowed the mandate and role of the OIG in overseeing programme implementation issues.

Lack of transparency at the GF board level and its unwillingness to address the issues raised by its OIG, aided by pre-existing Soviet legacies and local democratic deficits, outlined by Bruno (1998), Wedel (2001), and Carothers (1999b) discussed in Chapter 1, enabled PRs on the ground in Ukraine to implement highly discretionary, top-down programmes. The high discretion and top-down approach were manifested in PR control over target setting, in channelling funding to Sub-Recipients, and in control over monitoring and reporting systems. The result was to allow PRs to set their own performance benchmarks and declare them as results with no oversight.

The CCM model turned out to be a "testing ground for Ukraine" (Brusati 2003, p. 24), rather than became a governance mechanism:

- CCM functioned not as genuine country-owned governance body, but as a 'quasi' governance structure established to support GF country application and funding processes, with no real oversight or mandate to re-programme GF funding. It passively adopted PR-imposed targets, monitoring, and reports. The CCM, members of which were unpaid, did not exercise decision-making authority.

- For prolonged periods during Rounds 1 and 6, there was no functioning CCM, and stakeholder meetings were the *de facto* governance mechanism for GF programmes. Stakeholder meetings were called and run by PRs, with agendas and participants influenced by PRs.

- During the period studied, when it functioned, the CCM appeared to be dominated by a narrow segment of PR representatives, donors, and organizations linked to PRs.

- Government's role in GF programmes was limited. From a period of complete government withdrawal after the R1 suspension, it transitioned into PRs engaging selectively with officials at MOH and AIDS Services in CCM. Because of the nature of GF programmes and the specificity of the targeted populations (drug users, etc.), successful implementation required a broader policy consensus, including on drug policy, and necessitated a more inclusive CCM membership. The MOH, the government focal point for PRs, did not have the political weight to influence other and more powerful government agencies (Ministry of Finance, Ministry of Interior) over policy issues important for GF programme implementation. Lack of understanding of how political systems work in post-Soviet states may explain the persistence with which aid organisations continue to engage almost exclusively with MOHs.

Outcomes: The GF Country Coordination Mechanism was used narrowly and opportunistically by PR NGOs to promote their own interests and goals in relation to the GF programme implementation. CCM oversight mechanisms were non-existent for most of the time of R1-R6 grants. Due to weak governance, the national ownership of GF-funded HIV prevention programmes in Ukraine was not exercised, which ran contrary to the GF pledges that it "will base its work on programs that reflect national ownership and respect country-led formulation and implementation processes" (GFATM 2001, p. 1). The PRs were able to implement their own preferred approach through a network of Sub-Recipient NGOs, with little linkage to state health care systems and practices, and with the inconsistent involvement of important government stakeholders. The result is that the GF-funded HIV prevention programme is not owned by Ukraine and in its present state is unsustainable.

7.3 'Potemkin villages' of service coverage and monitoring

As noted in Chapter 1, Paris Declaration donors committed to "managing and implementing aid in a way that focuses on the desired results and uses information to improve decision-making" (OECD 2005, p.7). That included, among other measures, "to rely, as far as possible, on partner countries' ... reporting and monitoring frameworks", "link country programming and resources to results and align them with effective partner country performance assessment frameworks", and "harmonise their monitoring and reporting requirements .. with partner countries to the maximum extent possible" (ibid., p.7).Thus, the centrality of country-owned reporting systems was clearly articulated.

Even before the Paris Declaration outlined the pillars to make aid more effective, the GF formulated its founding principle — to provide funding to countries on the basis of performance (GFATM 2009). Performance-based funding (PBF) is a central pillar in the GF grant management where data on GF-funded services is routinely reported by recipients in countries. A number of sources have expressed concerns about GF's PBF model. One criticism is that it allows recipient countries to choose "their own performance indicators and target goals" to evaluate the performance of their GF grants (Glassman et al 2013, p. 46). Another criticizes a "superficiality of numbers that the Global Fund proudly announces as its 'results'" (Decosas 2012). In regard to GF in Ukraine, document sources reveal concerns that "the targets established were not always formulated adequately and supported with validated assumptions" (OIG 2012, p. 23). Drew (2005d, p.31) warns that that agreeing targets between PR and GF, without local involvement, could result in a "must achieve 100% mini project", a "negotiated agreement of what is needed and feasible within the time available". The outcome, Drew said, may be that the PRs "that understand how the process works will find it in their interest to set low targets to ensure they achieve higher scores in their grant performance report" (ibid., p.31).

As discussed in Chapter 1, GF programme implementation occurred in the context of pre-existing relationships and legacies, many of which were deeply-rooted in the Soviet system, which was a common feature to Western aid programmes in FSU (Wedel 2001). Analysis of primary data reveals how some of these legacies, rooted in particular in Soviet work practices and data reporting, were re-animated in GF-funded environments.

Participants reported PRs had full control over the whole data production cycle, including setting HIV prevention targets generated by PR-controlled 'expert working groups'. The persistent GF focus on performance-based funding was passed through to the PR INGO and on to Sub-recipients (SRs). Shortcomings in PR-practiced approaches to performance monitoring and SR management resulted in pressures on SRs to report 100% fulfilment of targets and a constant 'race for figures.' As discussed in Chapter 6, no real oversight systems were in place to monitor performance for most of the time of R1-R6 grants. Analysis of primary data aligns with document sources indicating lack of coordination and ownership over PR data monitoring systems. PR (Alliance's) focus on delivering results and meeting targets left "little time for considering …issues like coordination and building a national response" (OIG 2008, p. 19). As an outcome of weak governance, the PR had practically unfettered discretion to institute approaches and systems that allowed the PR itself to set and monitor its own service delivery targets, and to control, in fact, to assert ownership right in the data reporting systems paid for by GF with funds originally intended to support the country monitoring systems.

Among the issues identified by participants were the following:

- GF publicly stated that continued funding would be based on performance. The model failed to put in place independent oversight systems to allow countries to track PR-reported results. Instead, it allowed the PR to implement its own data collection systems and procedures that study participants describe as encouraging inflated reporting and data manipulation.

- Full control by the PR (Alliance) over the data reporting cycle allowed it to set targets for service delivery, shape reporting of results by its SRs, and then to control what was reported to GF. A key tool for the PR's control of results was a monitoring and evaluation database, funded by GF. This database recorded and aggregated data obtained from provision of HIV services. Some participants expressed concerns that because PR owned the database, it could access, alter,

and modify the data they had entered. The database was not certified by Ukraine's authorities.

- The focus on delivering 100% or more of results created a disincentive for innovation, experimentation, or truthful reporting. Ironically, those in charge of Ukrainian NGOs were practiced in the culture of over-reporting from their Soviet past, when bad results were discouraged, even if it meant data manipulation. SR organisations were forced to fulfil the target numbers with no possibility of re-programming, or otherwise they would not get another project.

- PR data reporting systems appear to have encouraged and at least permitted practices that amounted to double counting of data on HIV prevention services. Participants reported the PR reporting systems did not produce a fair reflection of actual performance, but encouraged *pripiski* (false reporting). *Pripiski* were done at both submission and implementation stages of SR projects. At the submission stage, NGOs were incentivized to write proposals with a 'pre-set' number of clients – even when the organization knew that the numbers promised either did not exist within its coverage area or could not be served with the funding requested. At the reporting stage, NGOs were also incentivized to exaggerate the number of services delivered – because under-reporting was discouraged and no systems were in place to detect exaggeration. Participants report the issue was widely known.

- Data collected by NGOs on HIV prevention services, was cumulative for most of R1-R6. Because NGO contracts were short-term, typically for one year, it meant that many clients who received services in the same NGO would be re-counted as new in new contracts and would show in growing cumulative figures each year, while the actual number of people reached would grow insignificantly or not grow at all. The coding systems that were meant to remedy this were also reported as open to manipulation by clients and staff of NGOs. As a

consequence, participants reported, double counting of clients was wide-spread.

The implications of the 'centrally planned' target setting by PRs on the example of Ukraine are far-reaching to understand how PBF model manifests itself on the ground. Drew (2005d) talked about 'pressure settings' where pressures to present 'on-target' data were high. He identified them as "all settings *where performance-based funding applies* and also in cultures *where targets were expected to be met or there would be fear of punishment"* (Drew 2005d, p. 11). [Emphasis added.] Analysis of interview data confirms that PR's monitoring systems in R1-R6 in Ukraine directly fit the 'pressure settings' definition: firstly, because PRs used performance indicators (as part of PBF), secondly, because they controlled the target setting – and the whole cycle of the data reporting, and lastly, because through their requirement of a 100% target fulfilment by SRs (targets to be met) in order to receive new grants (fear of punishment), they could influence that SRs report the right results.

Outcomes:

- It is argued that the data gathered by PRs are unreliable. The practices of data inflation, regardless of their scope, that were reported by participants, are a litmus test of serious gaps in data processing, and cast doubt over the accuracy of coverage data reported by PRs. The need to reach targets quickly in order to process massive funding from GF may explain why these practices exist. The 'performance-based funding' model of GF aid delivery that envisioned "... a level of substantive accountability – meaning results – that's unheard of in international development assistance" (Bush administration official, cited in Schoofs and Phillips 2002) did not appear to be realised on the ground in Ukraine. Lack of unified standards of services, wide gaps in understanding basic definitions, including 'clients', 'coverage' and 'services', as well as practices of multiple NGO contracts, overlapping clients and NGOs reporting cumulative coverage, contribute to the uncertainty about PRs performance results.

- The PR ownership of data and reporting systems, not certified by national authorities in Ukraine, is dubious. Its use by GF-funded PRs does not correspond to what donors and GF pledged in the Paris Declaration: "to rely, as far as possible, on partner countries' ... reporting and monitoring frameworks" (OECD 2005, p.7). How a GF-funded data reporting system could end up to be owned by several of the PR's managers is inexplicable, underscores serious oversight problems of GF programmes, and appears to bear a conflict of interest.

7.4. Servile NGO sector: implementers, not advocates

As discussed in Chapter 2, the decision to transfer funding from a state-centred programme to an INGO was GF's own decision (Drew 2005, OIG 2008). The perceived strength of the PR INGO as having established links with other NGOs in the country and 'partnership relationships' among the Alliance and other NGOs were considered as key to the success of the GF programme (Drew 2005).

The starting point for the analysis of NGO relations during the GF implementation was determined on the basis of literature sources on the roles of NGOs in development. Chapter 4 discussed the implications for Ukraine of two issues raised in the literature:

- Following Ibrahim and Hulme (2010), NGOs typically exercise three primary roles, namely: advocacy, policy change and service delivery.
- Rich-country NGOs *operate as donors with respect to NGOs and even to the state* in poor countries when they "unilaterally decided where, with whom and regarding what they want to work" (Engberg-Pedersen 2008, p.1).

In many other Eastern European countries, for HIV NGOs, the need to secure funding occurred "on the landscape of political and moral messages regarding HIV and the need to serve their clients" (Owczarzak 2009, p.422). Ukraine's NGO context was profoundly altered by the GF entry. Not only was there little domestic discussion about the political and moral messages important to HIV prevention, the

fact that funding was given directly to the INGO by the GF demonstrated that this NGO did not emerge or develop from within civil society in Ukraine. Nor was its recipient status a result of a wide national initiative; rather it was a GF-appointed advocate.

The 'donor-like' role of PRs manifested in the context of CCM governance, as discussed above. It also led to "a shift of inter-organisational relations" after the GF R1 grant transfer (Drew 2005c). In these relations, Alliance was seen acting 'as a donor', and the possibility that organizations might receive funds from Alliance "affected the nature of the relationship between the organizations" (Drew 2005c, pp. 14-15). In R6, dependency of local NGOs on PRs deepened. One report acknowledged "a widening rift between the powerful national organisations and smaller regional NGOs" (Druce et al. 2008, p. 10).

The concept of PR NGOs acting as donors to other NGOs was further applied in analysis of country documents and interviews.

The decision to transfer a government-focused grant to an INGO, and later to its local subsidiary, disadvantaged the emerging national civil society in Ukraine. To implement its programmes, GF demonstrated a preference for externally-linked NGOs. Drawing from the participants responses, a cluster of regionally established NGOs with a harm reduction focus and previous international donor funding appears to have assisted in the transfer of the GF grant from the government. To those not involved in engineering the transfer, the narrow HIV prevention agenda with its focus on injecting drug users did not allow room for a broader stakeholder involvement.

As shown in Chapters 4 and 5, Ukrainian civil society sector was co-opted through competitive and PR-controlled channelling of funds, producing a servile NGO community with weak advocacy capacity. PR NGOs, acting as donors in channelling GF funding, ran highly discretionary policies of Sub-Recipient funding, by which they classified SR NGOs as possessing '*a unique capacity'* or *'exclusive capacity and experience',* as '*favoured implementers'* and so on (Alliance 2007, p. 6). Local NGOs, instead of looking out to better serve their constituencies, had to

endure a permanent competition among themselves for "donor largesse" (Spicer et al.2011, p.1751), and succumb to vertical, contract-based relations established between NGO-grantors and NGO-grantees, with a wide-spread "culture of fear" (ibid.,p.1751). With GF the largest HIV funder in most *oblasts*, the only alternative for NGOs was 'get a GF grant or perish'. This contradicts the initial GF assumption that PR NGOs would be capitalizing on the existing NGO networks. Instead, local grass roots NGOs lost the voice to articulate where the real needs lay, and turned to trumpeting the 100 percent success of PR-defined approaches and targets. In the words of one participant, local NGOs "moved from being leaders of the third sector to servile implementers". Advocating for broader policy issues or for re-programming GF funding to meet the actual needs in their *oblasts* would have threatened their own funding. Lack of broader civil society engagement with government compromised its capacity to advocate scaling up future domestic funding in case of donor exit.

The distribution of Sub-Recipient NGOs was uneven within the eight of 24 regions. GF-funded services were purportedly targeted and delivered at 'high priority' regions and "focused on regions of higher prevalence rates and in larger cities" (OIG 2012a, p. 22), which followed prior patterns of donor aid in Ukraine. Even at the time of peak GF funding, when R1 and R6 programmes overlapped, the 'scaling-up' of HIV prevention services did not spread beyond the "high-priority" regions. This was also confirmed by interviews.

Significant amounts of GF funding went to about a dozen well-established, well-connected NGOs in "high-priority" regions – 'mega NGOs' that were already well-funded before the launch of the GF programme. The rationale for PRs to engage with some SR NGOs non-competitively was rooted in their discretionary grant making and was explained by the need for PRs to be "flexible in adapting ... to specific circumstances" and thus bringing in "some NGOs [that] had been through a previous competitive process" (Drew 2005a, p.10). The use of 'established' NGOs appeared to be consistent with the need to spend money quickly. It enabled the proliferation of larger regional NGOs – influential power blocs that were funded continuously – because they had been through "a previous competitive process". Chances of new NGOs without a prior SR experience to be funded were low.

Due to the practices of double counting in data monitoring, 'Mega' NGOs were able to generate large coverage numbers from one *oblast* that were passed on into national coverage statistics and to the GF. Massive overlap of NGO-provided services within the same city allowed for a duplication of services when clients were able to walk from NGO to NGO in the same city and receive multiple services. This practice appears to have been well-known.

A problematic element of GF funding was reported as associated with hiring of licensed medical professionals by HIV-service NGOs. This practice allowed NGOs to deliver specific medical services, as well as allowed them to deliver, without resistance from local officials, harm reduction interventions that were viewed as politically or morally controversial. GF-funded NGO service delivery that required formal local government approval often led to NGOs being co-opted by state health officials and AIDS centre head doctors. This resulted in creation of hybrid, 'quasi' NGOs in the regions, run by health officials or AIDS centre doctors. The ambiguous nature of NGO involvement with government officials at both national and regional levels was also reported. The engagement by NGOs of state officials as GF-funded consultants was a common feature in an environment where GF-funded interventions were seen as politically controversial, and often not fully legal, such as syringe exchange. It represented, in the words of one participant, "buying loyalty from the state". The ease with which such NGOs appeared should be viewed not as a sign of a deregulated, 'free' sector, but of a weak civil society, trapped between dependence on external funding and the need to survive under the pressures of state bureaucrats that viewed NGOs as a lucrative ground for themselves. The NGOs seeking approval from local government in order to get GF funding could not be effective advocates, and local advocacy potential was seriously impaired or lost altogether. Involvement of AIDS centre doctors in organisations of patients whom they were supposed to cure and protect, getting funding on their behalf, constituted a conflict of interest and a gross violation of ethics in 'doctor-patient' relations.

<u>Outcomes:</u>

- GF selected an international NGO and its subsidiary, without a competition and for many years, as PR to run its programmes. Ukraine's own NGOs, however, were co-opted competitively through PR-controlled grant contracts and were used opportunistically to deliver services and generate coverage data. This resulted in a servile NGO community with a weak capacity to advocate for issues outside the GF programmes' scope.
- Because its cookie-cutter programmes imported from elsewhere were not designed for the Ukrainian legal, political, and cultural context, PR had to engage state health care workers in GF-funded NGO settings. This facilitated NGO hybridization, and the appearance of 'quasi' NGOs run by officials or AIDS centre doctors. In an environment where GF-funded interventions were seen as politically controversial, the engagement of state officials in GF-funded NGOs represented, in one participant's words, "buying loyalty from the state".
- Due to their privileged status, explained in detail in Chapter 4, 'mega' NGOs in 'high priority' regions were influential in the GF-funded proliferation of activities during R1, including target setting and monitoring of service delivery data. 'Mega' NGOs, based in large cities in 'priority regions', generated high-digit coverage data. This data was then passed on to the PR national coverage data reported to GF under the Performance-Based-Funding (PBF) model. In reality, this data was inconsistent and cumulative, concocted from imprecise and conflicting definitions of "client" and "service package", with numbers generated from counting the same clients as new again for multiple contracts, counting multiple visits of the same clients, using absent clients' cards, etc. The PR-owned data reporting systems enabled these practices.

Conclusion

The implementation of GF-funded HIV prevention programmes in Ukraine provides specific examples of general weaknesses in the GF model that others have critiqued in regard to the traditional aid programmes, as noted in Chapter 1, including the CCM governance structure, weak monitoring and evaluation systems, and the

performance-based funding model. The outcomes described above also suggest that, as implemented, some of the same flaws assigned to earlier, traditional donor programmes by aid effectiveness critics, were manifested in GF programmes in Ukraine:

- Williams (2009) complained that donor programs too often solicited negligible feedback from beneficiaries and their impacts were difficult to observe.
- Prokopijevich (2006, p. 19) criticized the pattern of "mass deception through reporting and evaluation."
- Easterly (2003, p. 34) described donor programs that function "as a cartel of good intentions, suppressing critical feedback and learning from the past, suppressing competitive pressure to deliver results, and suppressing identification of the best channel of resources for different objectives."

It was precisely such flaws that the GF as a new aid delivery model, compliant with the principles of the Paris Declaration, was intended to avoid. In this light, the Conclusion to this thesis that follows will address whether and to what extent GF programmes can be sustainable in the event of the GF exit from Ukraine.

Conclusion. The exit of the Global Fund and the future of HIV prevention in Ukraine

The perceptions of aid by donors and recipients are very different. Citizens of donor countries might expect their foreign aid money to be received with gratitude and without expectations for how it should be used, trusting that Western political systems, democratic values and good intentions will produce effective programming that improves lives in recipient countries. For those of us 'on the ground', or rather, deep inside the aid delivery quagmire, such attitudes appear naïve. We lack trust in good intentions, because, based on decades of experience, we understand the catastrophic harm that ignorance and arrogance can unleash, as discussed in Chapter 1. Faith in Western democratic institutions has little relevance in the context of our own countries where aid is being delivered. We have even less faith in our own post-Soviet 'democracies' and their ability to manage the incoming aid on our behalf. This mostly skeptical perspective was expressed at the beginning of this enquiry and provided for a 'critical space' in order to examine the effects of aid and how it is perceived 'on the ground' in Ukraine.

At the same time, the existence of multiple modern approaches to HIV prevention and care, increased access to new and more effective diagnostics and ARV drugs, as well as the existence of strong global health advocacy networks supported the belief that new elements from outside could be incorporated into the existing health care systems in Ukraine. We believed that the state health sector, although affected by transition, was capable of moving forward with ART provision and other health services. Ukraine, among many other FSU states, also had powerful and growing civil society, and expectations were high of its 'Third sector' capacity in HIV/AIDS advocacy and service delivery. With this understanding and these hopes, a comprehensive, nationwide, HIV prevention and treatment programme, developed with a strong government support, centred on government health system, and with participation of civil society, was approved for GF funding. This thesis has described how that programme was taken away and another, more narrowly focused program, centred on NGOs to deliver services, substituted in Ukraine. This research has examined the effects of the Global Fund programme transfer to the INGO it selected,

implemented by non-governmental entities, on the HIV health sector and policy relationships and services in Ukraine.

Aid divides. The aid programme, even before it arrives, already divides the country's government, parliamentarians, business and expert communities, NGOs, ethnic, faith, gender and age groups, and population at large into stakeholders, beneficiaries, and the rest. Most aid programmes in the way they are run are divisive in principle – aid is being given only to a particular cause, for a particular group and for a particular time. Those who are presumed beneficiaries – the end recipients of aid - are so divided in their opinions that special methods are needed to examine them. In some cases, beneficiaries, if asked, do not want to receive what donors want to give. The donor side of the aid narrative has been clear-cut: the givers know better than takers where and for what the money should go.

All that was meant to change with the Global Fund. Established to over-ride the fallacies of previous aid delivery models, its programmes were meant to be run based on the principle of country ownership. Countries themselves, in a broadly inclusive process, would determine where their needs lay, and how to tackle them. Once the GF was satisfied with country-developed programmes, it would provide the funding that supported implementation. Indeed, GF documents explicitly incorporate the principles of the Paris and Accra Accords:

> As a signatory to the Paris and Accra Accords, the Global Fund will abide by the guiding principles of alignment and harmonization. At the country level, the Global Fund will emphasize the alignment of its grant cycle with country planning and budgeting cycles, and harmonization of salary support and compensation.
>
> The Global Fund will encourage CCMs to be more in line with other national coordinating bodies. (GFATM 2010a)

The innovative GF model of aid delivery was supposed to create systems to deliver balanced programming. Stakeholders in each country would develop interventions to meet their own specific needs. CCMs would assure broad representation in program development and oversight, with members drawn from the public sector, NGOs, and those living with the targeted diseases and their communities. GF procedures and oversight would prevent kleptocrats – usually

government officials – from stealing the money. And the communities of people with the diseases targeted would have influence over funding decisions.

In some respects, the model succeeded. Ukraine's government did not divert the funds, though some health sector officials and their quasi NGOs did well. GF grant recipients were non-governmental organisations, including the one representing the community of people with the disease.

Yet, drawing on the available evidence, this thesis asserts that despite its guiding principles and contrary to its own ongoing narratives about its much-touted best practice approaches, GF-funded aid model as implemented in Ukraine, does not appear, as noted by its former IG, to have delivered value. In fact, its programmes may have adverse impacts and distorted state health sector capacity for prevention and treatment and, more importantly, have made HIV prevention unsustainable.

The delivery of GF aid programmes brought in and institutionalised multiple divisions that had adverse effects on the country's ownership of HIV prevention efforts, on relations of civil society with the state, and on national governance. In the context of democracy, the grant seeking and *grant-eating* practices that were enabled by massive GF funding had a detrimental effect and corrupted Ukraine's nascent HIV/AIDS civil society. The ability of NGOs to advocate for issues broader than GF programme delivery was severely impaired. Some civil society actors engaged in opportunism in their promotion of narrow GF-funded prevention ideologies.

The 'stand-alone', isolationist manner, in which HIV prevention programmes were run by PRs, undermined national ownership. The state health sector was largely bypassed by NGO-centred programmes, systems, and practices. Instead of generating a broader policy dialogue and making HIV a public concern for all, the PR NGOs and GF continued to articulate a more narrow 'prioritisation of those most-at-risk' which was not perceived as fair by society and medical community, ravaged by multiple diseases and collapsing health care. In reaching those 'at-risk' though, the PRs did not appear to have consistent service standards or to reach out to most parts of the country. Only eight of 24 regions appeared to have been covered by most of GF-funded services. The narrow programmes run by GF-funded PRs and their SRs,

some of which were inconsistent with Ukraine's legal framework, lacked a broad national constituency. Nor does it appear that they could be implemented independently of the current PRs, who own the data monitoring systems and other programming materials, etc., developed over the years. Thus, attempting to prolong GF-programmes in the absence of GF funding would require extra funding to replace systems and procedures that GF has already paid for.

The important question therefore is what the implications will be for HIV prevention services if Global Fund exits from Ukraine. The most recent GF communications suggest it is leaving countries like Ukraine that have achieved middle-income status, and will be focusing on disease 'hot spots' and target high-risk populations. In Ukraine, PRs and their NGO grantees, supported by the GF, assert that GF-funded HIV prevention has been effective, and the government should now provide replacement funding to continue the programming. Others argue that GF has to stay and continue funding the existing approaches.

A GF exit from Ukraine would come at the worst possible time. The country is in dire economic straits and racked by civil war. Funding for HIV prevention and treatment initiatives would compete with modernizing the military and maintaining public electricity and heating systems. It may be that to curry Western favour, upon which its survival may depend, the current government accepts the GF exit conditions and takes over funding of badly regulated, controversial, non-standardised HIV prevention services run by NGOs. The Ministry of Health has given assurances about continuing engagement with GF after its exit. It is unclear how the current political and economic crisis will affect Ukraine's relations with the GF, and whether it will expedite its exit scenario. (Most of this thesis was written before the crisis in Ukraine commenced in February of 2014.)

Transfer of HIV prevention to domestic funding faces several challenges. The PR NGOs' advocacy for this approach may be viewed as defending their own self-interests. The current narrowly-focused HIV prevention programmes will be subject to challenge by other country stakeholders who have not been engaged in past planning and delivery of interventions. The government may co-opt a number of NGOs to implement its own HIV prevention approaches as it sees them. Some of

these NGOs are already in existence as an aftermath of NGO hybridisation in GF-funded settings, described as ‘quasi NGOs’ in this thesis. Other NGOs may be opened to enable utilisation of ‘social contract’ budget allocations, when those become available.

Similar developments can already be observed in Russia, where the government moved to fund its own version of HIV prevention, and significantly overhauled the direction of programming. Most of the previous GF-funded service providers were replaced with different organisations that focused on healthy life style, drug treatment and rehabilitation services, and re-integration of drug users introduced as the key policy directions of state services. The GF is only marginally present in Russia, funding a segment of NGO-based regional harm reduction projects that are often in conflict with government policies.

If GF exits from Ukraine, the government will have to take responsibility for HIV prevention and treatment. As was the case in Russia, government may well replace GF-funded programs with an entirely different approach, especially given Ukraine’s current financial crisis. The way to deal with the transition from GF to government funding may be to move the HIV prevention services from being focused on ‘outreach’, field services, to a ‘closer-to-care’ approach that would shorten and improve linkages to the state HIV care continuum, and institute stronger referral protocols for entry into care, currently missing. For this, effective, permanent, and legally defined standards need to be developed and nationally adopted for HIV prevention service delivery. Clear definitions of ‘coverage’, ‘client’, and ‘service’ need to be adopted and costed in a manner consistent with relevant legislation. A well-functioning, predicable and sustainable system of NGO-run services needs to be established and nationally funded. The scope and level of NGO services should not be competition-based, but regional needs-based. An NGO-run system that can effectively demonstrate and reliably document coverage and service delivery would raise the status of NGOs in dialogue with the state and local governments, and move NGO services closer to integration into state health care.

All the existing HIV prevention capacities, including those created with GF funding, need to be mapped in order to be effectively coordinated by country-run,

nationally-owned systems. Overall, a full and independent audit of all available HIV prevention services that are currently delivered is much needed in Ukraine, without which attempts to integrate prevention and care are doomed. The language of concentrating prevention in some groups in some regions needs to give way to a broader and more holistic approach to HIV prevention that would benefit the whole population of Ukraine and generate a broader policy response to the threat of Europe's fastest growing epidemic.

However, given most of the recent statements by GF leadership, it does not seem to support holistic prevention. Its leadership uses phrases like seeking 'the biggest bang for the buck' and focusing on 'hot epidemiological spots'. Whether and how well GF will continue to engage with countries that adopt different HIV prevention and treatment models remains to be seen. But under the new approach as articulated, country ownership may mean the country is abandoned if its choices do not conform to GF's requirements.

Sadly, it appears from the evidence and document analysis reported in this thesis that, as experienced in Ukraine, the high expectations for GF aid delivery have not been met. In many respects, the country ownership model was never allowed a chance to succeed. Government was pushed out of the process early on and control passed on to an international NGO. The original country-owned programme that envisioned a nationwide, comprehensive programme covering the entire population was replaced, without national debate, by a narrowly targeted focus on some, but not all, high-risk target groups in a limited number of high-priority regions. A vibrant NGO community was undermined, converted into grant-eaters that collaborated in churning out unreliable data to justify continued funding. How could this approach be sustained? More importantly, even if resources were available, why should it be sustained? Despite the high hopes and great expectations, GF's legacy is likely to be an all too familiar phenomenon – a donor programme that disappears when funding dries up, leaving behind shrivelling NGOs that no longer have the means or resources to carry on a programme, and weakened in front of their governments. And in the background of wasted opportunity, the key issue still remains, how Ukraine,

Europe, and the world will continue to respond to the world's fastest growing HIV epidemic.

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• Ukrainian Law No. 1026-VI On adoption of National Program on HIV prevention, treatment, care, and support for the HIV-infected and AIDS patients for 2009-2013, dated 19 February 2009.

• The National Programme ‘Reproductive Health’ for 2001-2005

• The State Programme ‘Reproductive Health of the Nation’ for the period till 2015

• The State Program on assertion of gender equality in Ukrainian society for the period up until 2010

• Report on implementation results of the National Program for HIV prevention, and care and treatment for HIV-infected and AIDS patients for 2004-2008

• Report on the results of implementing in 2008 the State Program Reproductive Health of the Nation for the period up until 2015

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Social Policy of Ukraine ‘On measures to prevent HIV MTCT, health care and social support to HIV-infected children and their families’ dated November 23, 2007.

• Order Nº 236 of the Ministry of Health of Ukraine ‘On introducing voluntary counselling and testing for HIV infection’ dated April 19, 2006.

• The Order Nº 716 of the Ministry of Health of Ukraine ‘On approval of clinical protocol for obstetric care to prevent MTCT`.

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• State standards for basic and comprehensive secondary education.

• Order Nº 132 of the Ministry of Education and Science of Ukraine ‘On approval of Standard curriculum model for comprehensive (12 years’) schools’ dated February 23, 2004.

• Order N°1133 of the Ministry of Education and Science of Ukraine ‘On Curriculum approval Basic educational guidelines for pupils attending the 1st -12th forms in comprehensive Schools’ dated December 17, 2007.

• Participation of churches and religious organizations in Ukraine in combating HIV/AIDS epidemic and work with PLWH (inter-confessional book).

APPENDIX A: Global Fund Recommended "Top Ten" Key Performance Indicators

Table 1: Top Ten Indicators for Routine Global Fund Reporting

	Disease	Indicators for routine Global Fund reporting
1	HIV	Number of adults and children with advanced HIV infection currently receiving antiretroviral therapy
2	TB	Number of (a) new smear-positive TB patients detected, (b) new smear-positive TB patients who were successfully treated and (c) laboratory-confirmed MDR-TB patients enrolled in second-line anti-TB treatment
3	Malaria	Number of (a) insecticide-treated nets or re-treatment kits distributed to people and (b) households (or structures or walls) in designated target areas sprayed by indoor residual spraying in the past 12 months
4	Malaria	Number of people with fever receiving antimalarial treatment according to national policy (specify artemisinin-based combination therapy versus other therapy)
5	HIV	Number of women and men aged 15-49 years who received an HIV test in the last 12 months and who know their results
6	HIV	Number of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission
7	HIV	Number of condoms distributed
8	HIV, TB and malaria	Number of people benefiting from community-based programs: specify (a) care and support including orphan support, home-based management of malaria and directly observed therapy (DOT); (b) behavior change communication outreach activities including specific target groups; and (c) disease prevention for people most at risk (except behavior change communication)
9	HIV/TB	Number of TB patients who had an HIV test result recorded in the TB register
10	Strengthening health systems for HIV, TB and malaria	Number of people trained

(CGD 2013b, p. 44).

APPENDIX B. Sex work, prostitution and sexuality in Ukraine and Russia: a historic overview

In tsarist Russia, prostitution was regulated and confined to brothels (*publichnye doma*) where prostitutes lived and worked, subject to medical examination. This system was well-described in the Russian 19th century literature (Tolstoy, Bunin, Dostoyevsky, and others). Prostitution in Halychyna was illegal at the times of the Austrian Empire while some individual prostitution was allowed at home. Often with direct involvement of the Austrian authorities, Ukrainian women were trafficked into brothels as far as in Istanbul, Bombay, Buenos-Aires, Rio in the 19th century. In 1920s-1930s when Halychyna was Polish territory, prostitution was confined to special streets, similar to 'red light' districts in European capitals. During Nazi occupation of Ukraine in 1941, many local women were drawn into prostitution despite Himmler's ban on sexual relations with "inferior" people (Gertjejanssen 2004).

In Soviet Union, prostitution was de-criminalised. It was an administrative offence with minimal fines. Soviet view on prostitution was based on perception of prostitution as existing mainly in the capitalist society where women were forced into sex work by joblessness and lack of education. Prominent Bolshevik feminist leader Alexandra Kollontai - Commissar for Public Welfare in 1917-18 – was an advocate of 'free love' and proclaimed that family *'is ceasing to be necessary either to its members or to the nation as a whole'* (Kollontai, 1977). Kollontai advocated strongly against prostitution:

> *And what, after all, is the professional prostitute? She is a person whose energy is not used for the collective; a person who lives off others, by taking from the rations of others…from the point of view of the national economy the professional prostitute is a labour deserter. For this reason we must ruthlessly oppose prostitution. In the interests of the economy we must start an immediate fight to reduce the number of prostitutes and eliminate prostitution in all its forms. (Kollontai 1977, p.266)*

Early attempts of Bolshevik sexual emancipation did not survive and, with the emergence of Stalin in the 1920ies, abortion was outlawed (until 1955) and puritanical attitudes predominated, when sexuality became a taboo subject in mass media, scientific investigation, and education and the only legitimate function of sexuality was reproduction (Hovorun and Vornyk 2004).

APPENDIX C. Health care organisation in the USSR: the 'Semashko' system

Outpatient care was provided by the *uchastkovyi vrach* (catchment area therapist or paediatrician) to the assigned adult/child population in their catchment area (*uchastok* in Russian*)* or at district (*rayon*) polyclinics. The **inpatient care** was organized into three levels: the first (lower) level of rural hospitals provided basic inpatient facilities; the second (middle) level - secondary inpatient care – was provided in central district and oblast multi-profile hospitals, specialized clinics (dispensaries), and specialized hospitals; and the third (higher) level of regional and supra-regional specialization - tertiary care - for more chronic and complicated conditions - provided by republican hospitals, research centres and specialized clinics in large cities.

Tertiary care services were also vertical, organised by disease-centredspecialties, each with its own system of institutions – TB dispensaries, drug dispensaries, infectious hospitals etc. Large industry employers (railroads, defense, police etc.) as well as the prison system, all had separate health care systems. Vertical health care remains characteristic of the Ukrainian health care system (Lekhan et al, 2004).

Soviet healthcare was based heavily on prevention and made significant advances in preventing infectious and other diseases through compulsory vaccination and annual "*dispensarization*" (health check-ups) for all citizens (Rowland and Telyukov 1991). An important element of the Semashko model was the extensive system of epidemiological monitoring networks - *SanEpid* (Tragakes 2003).

A vertical, command-based system with no world analogues, *SanEpid* (Sanitary-Epidemiological) Service, or SES was established by Semashko in 1918-20 to respond to a devastating typhus epidemic that took millions of lives, when Lenin is reported to have uttered a famous phrase, "if socialism cannot conquer lice, then lice will conquer socialism" (cited in Muller et al, 1972). A massive and zealous public delousing campaign was carried out that succeeded in stopping typhus in Soviet Russia (Garrett, 2000). Later, thousands of *SanEpid* stations monitored mass obligatory vaccinations, sanitary protection of water supplies, vector control of malaria, disinfection, pest eradication, hygienic disposal of waste and sewage, milk pasteurization, etc. (Glass, 1976) In late Soviet times, the focus of SanEpid shifted to occupational health and environment, and it was responsible for setting and maintaining numerous standards and norms. Overall, *SanEpid* was able to bring under control most existing epidemics of the time, and can be viewed as a model of preventive medicine that was effective in the Soviet context.

Beginning in the 1970s, more emphasis was placed on the hospital as a provider of care (Rowland and Telyukov 1991). The budgeting approach was based on the notorious 'bed-unit' (*koyko-mesto*) system, under which the service capacity of a health care institution was measured by the number of hospital beds and of health personnel (Lekhan et al, 2010). Socialist planning was oriented towards the goal of ever-increasing this capacity. In 1990, just before the collapse of the USSR, Ukraine and other Soviet republics had among the world's highest numbers of hospital beds and physicians per capita (World Bank, 1995).

APPENDIX D Variability of HIV/AIDS estimates in donor-funded research in Ukraine

Between 2005 and 2011, three comprehensive studies have were being conducted to estimate the size of populations most-at-risk for HIV infection (Berleva et al, 2012) as well as national estimates for the number of PLWHA, fully or partially funded out of GF grants. A wide and diverse combination of various research methods was practiced in these studies.

However, in 2012 UNAIDS acknowledged that data on HIV/AIDS made in previous years was incorrect "due to differences in calculation methods and differing versions of the software used for estimates generation" (UNAIDS 2012b, p.2). The developers of the new estimates urged *not to use the estimates from previous years* and "encouraged all users to accurately and consistently cite and use the data, as figures which have been approved by the National Council on TB/HIV/AIDS on March 29, 2012" (ibid., p.1). [emphasis added] A CCM approval thus constituted a decision making mechanism, with similar regional targets endorsed by Regional CCMs in oblasts. Only in 2012 – almost ten years after the GF began work in Ukraine – research protocols on the estimation of the size of most-at-risk populations began to be endorsed by the State Service of Ukraine on HIV/AIDS and Other Socially Dangerous Diseases. (Berleva et al. 2012, p. 8)

APPENDIX E. HIV testing in Ukraine: four stages

1) At the first stage, the previous Soviet model of mass HIV testing worked: from 1987 to 1994, 39,226,986 tests were carried out (Barnett et al, 2000). In 1993 alone, some 7.3 million persons were tested for HIV. Vast numbers of tests were carried out to identify very few infected persons as the epidemic was low.
2) The second stage, from 1994 until March of 1998, saw a major decrease in the number of tests as a result of changes in financing of test-systems and their distribution, as the previous centralized purchases by the national government were replaced by requiring local budgets to cover these costs. During this period, only few oblast AIDS centres had their own laboratories, and blood samples from all other oblasts had to be transported to Kyiv.
3) During the third stage, from March of 1998 until 2002, screening numbers fell further, following adoption of the Law "On Prevention of AIDS Incidence and Social Protection of People", which made HIV testing voluntary. Some sources note that, while conforming to international standards and aiming to protect the human rights of PLWHA, the introduction of the new system made the collation of data obtained prior to and after 1998 complicated (British Council 2011). This period is also associated with the dissolution of the AIDS Committee in May 1998 and scandals over testing systems. Thereafter, the state budget only funded the purchase and distribution of test systems for donor blood screening. Testing for other purposes devolved to local budgets.
4) The fourth stage – from 2002 to present – has been characterised by changes in the state framework for PMTCT [99] within the National Program. Procurement of HIV-antibody tests for pregnant women began to be fully funded by the state.

[99] Preventing Mother-To-child HIV transmission

APPENDIX F. The GF funds harm reduction in Ukraine: a success story.

THE GLOBAL FUND FUNDS HARM REDUCTION IN UKRAINE: A SUCCESS STORY

The Global Fund has been supporting HIV and harm reduction programmes in Ukraine since 2002. Rounds 1, 6, and 10 HIV grants have targeted populations most vulnerable to HIV, namely people who inject drugs, sex workers and men who have sex with men.

Highlights of the programme include the following:

- HIV prevalence among new injectors (people who inject drugs for less than three years) has declined from 29.9% of new infections in 2004 to 5.5% of new infections in 2011.
- National HIV incidence rates have fallen dramatically.
- The national HIV prevention programme reaches approximately 50% of people who inject drugs.
- OST was introduced in 2009 after a long advocacy effort. The programme had reached 6,632 people as of January 2012, leading to a range of health and social impacts such as reduced injecting, increased employment and reduced criminal activity.
- Over 120 civil society organisations across Ukraine have benefited from increased HIV prevention and care capacity-building programmes.
- State and civil society HIV programmes have become more integrated.
- Programming has been cost-effective, and programming innovations have included large-scale peer-driven interventions; pharmacy-based NSP; the introduction of rapid tests for HIV; new programming for stimulant users; and programmes and services for women who use drugs.

The International HIV/AIDS Alliance in Ukraine has been a Principal Recipient for the three Global Fund grants, amongst others. Alliance Ukraine has demonstrated the ability of civil society organisations to implement high-quality large-scale HIV programmes in settings where governments will not or are unable to prioritise HIV prevention services for marginalised groups.

A ten-year advocacy effort to engage the Ukrainian government in the HIV prevention/harm reduction programme – in implementing, policymaking and funding roles – has been only partially successful. The government remains largely uncommitted to the HIV prevention effort targeting people who inject drugs, and refuses to dedicate appropriate levels of domestic health funds to the national HIV prevention programme.

In light of the government's persistent resistance to harm reduction and to HIV prevention among vulnerable groups, the success of the Ukrainian HIV prevention programme remains dependent on international resources, in particular the Global Fund's resources.

Summary report of the ICF International HIV/AIDS Alliance in Ukraine on the performance under the "Support for HIV/AIDS Prevention, Treatment and Care for Most Vulnerable Populations in Ukraine" Program supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria. February 15, 2012 www.aidsalliance.org.ua/ru/news/pdf/23.02.2012/EN_narrative_%20report_jul_dec_2011.doc

Two friends receive information, advice and materials, including clean syringes, through a street outreach programme in Cherkassy, Ukraine © the Alliance

(International HIV/AIDS Alliance, 2012b, p.10)

APPENDIX G. Research information sheet.

Queen Margaret University

EDINBURGH

Information Sheet

My name is Svetlana McGill and below is information about a research project that I am conducting at the Institute for International Health and Development at Queen Margaret University in Edinburgh. The title of my project is 'Impact of the Global Fund Grants on HIV Prevention Policy and Services in Ukraine'. The research will be conducted in several regions of Ukraine, one of which is your region.

As you may know, the Global Fund against AIDS, Tuberculosis and Malaria (GFATM) is the largest international donor in public health. Ukraine has been receiving grants since 2002 and is at present the largest single GF recipient in Eastern Europe and Central Asia region.

The purpose of my research is to find out how the prevention policies and interventions that were developed during the implementation of GFATM grants, influenced national HIV prevention policies and HIV services in Ukraine.

There have been many publications about HIV/AIDS epidemic in Ukraine, including a number which mention the work of the Global Fund in Ukraine. According to some estimates, Ukraine has developed the most severe HIV epidemic in the whole of Europe and Eurasia, with adult HIV prevalence estimated at 1.6% in 2008 – the highest in Europe[100]. The severe character of Ukraine's epidemic remediates the need to look at the effectiveness of HIV prevention interventions and policies, as most of them were funded through the GF programmes.

In Ukraine, there is little state support to nationally-based social policy research, including research on HIV prevention policy and services, and most studies are conducted at the initiative of donor organisations. In this context, the nature of policy making in Ukraine and justification for adopting this or other policy often remains obscured or viewed as an outcome of donor recommendations. The NGO context in

[100]UNAIDS. 2008 Report on the global AIDS epidemic

which GF programmes are run presents a particularly interesting case for analysis. While much of existing research on GF in Ukraine has focused at the national level, the regional perspective was often limited.

It is the author's belief that most of HIV prevention and treatment work happens at the regional or city/district level, where patients turn for health care and social services, and where they are referred to other health services by locally functioning NGOs. In this connection, your opinion, as an expert on HIV policy and services, health provider and organiser, is invaluable for the goals of this research. You are invited to participate in the research project.

There are some criteria, however, for you to take part. You need to be involved in the implementation or planning of HIV/AIDS programmes in Ukraine, either nationally, regionally, or internationally, and you need to have work experience or extended knowledge about the programmes supported by the Global Fund. Other than that, there are no special requirements and everybody is welcome.

Some of the questions will relate to practical aspects of HIV prevention work, and about HIV prevention approach that was chosen in GF-funded settings in Ukraine. You only need to provide your opinion about this. No data or figures will be required from you. You may be asked to comment on the existing systems of data collection about HIV services in Ukraine. We will not interview clients of HIV services. You will be free to withdraw from the study at any stage and you would not have to give a reason.

This is not an operational research. The research is conducted independently by the researcher, and is not funded by the Global Fund. Your name or other personal information will not be collected. The responses that you choose to provide, will be in disposal of the researcher only and will not be shared with any institution or organisation in Ukraine, or anywhere else. There will be no payment for taking part in the research. Results of the research may be used in preparing a doctoral dissertation at QMU, published in national and international journals, and presented at conferences.

I would be very glad if you would be able to dedicate your time to take part in the interview and answer some of the questions. I would be grateful for your collaboration.

Contact data of the researcher:

Name:	Svetlana McGill PhD Research Student
Address:	Institute for International Health and Development, Queen Margaret University, Edinburgh EH21 6UU
Email / Telephone:	SMcGill@qmu.ac.uk +44-131- 474 0000

APPENDIX H. INTERVIEW GUIDE

Questions to determine respondent's status, duration of experience and level of knowledge of the GF programmes

1. Do you have any knowledge about/experience with the programmes supported by Global Fund in Ukraine? If yes, for how long?

- less than two years;

- from two to five years;

- five or more years;

2. With which Rounds of GF grants on HIV in Ukraine do you have knowledge/experience of having worked with?

- Round 1 (2004-2009);

- Round 6 (2007-2012)

- Both rounds.

3. How would you best identify yourself in relation to GF programmes in Ukraine?

- state medical care sector (Ministry of Health);

- state non-medical sector (employee or official of State Penitentiary Department, State Social Services, Ministry of Education, Ministry of Interior, etc.);

- national NGO of Ukraine;

- regional NGO (oblast, rayon, town);

- independent expert, specialist;

- international intergovernmental organisation (UNDP, UNAIDS, WHO);

- international governmental organization (USAID, GIZ, CIDA, DFID etc.);

- international NGO;

- other (please describe which one).

4. What type of activities were you involved in/worked that is related in GF programmes?

- prevention (including among groups of high risk to HIV transmission);

- Voluntary Counseling and Testing (VCT) services on HIV

- treatment/administering ARV-therapy;

- referral of patients

- care and support, palliative care.

- reporting, preparing assessments

- several of the above.

MAIN BLOC OF QUESTIONS – TO BE ASKED TO EVERYBODY

For state and NGO sector:

1. What, in your opinion, is the character of HIV epidemic in Ukraine?

2. Does the understanding of the character of HIV epidemic influence the policy formation on HIV prevention? Why?

3. Which structures in Ukraine are responsible for HIV prevention?

4. What structures in Ukraine are conducting HIV prevention programmes? Please name as many as you know.

5. Please name, in your opinion, the main components for HIV prevention in Ukraine.

6. Are all of these included into the programmes of prevention that were conducted in Ukraine funded by GF? If not, which are included? Which are not included? Why?

7. What was the main focus of HIV prevention programmes funded by GF?

8. Do you know how priorities were determined for HIV prevention during the time of submission of Round 1 country proposal to GF? (year 2003).

If the answer ‘yes’, then ask the following question:

8a. What were the HIV prevention priorities after the transfer of Round 1 grant from government to HIV/AIDS Alliance?

BLOC OF QUESTIONS ON HIV PREVENTION NEEDS AND COVERAGE

9. Does Ukraine have a system to determine the needs for HIV prevention programmes?

If a respondent has answered 'yes' on this question, then two follow-up questions are being asked.

9a. Please provide a short description of this system, and nominate the HIV prevention needs from more important to less important (at least three needs).
9b. Please explain how it is determined that these needs are the most important.

If a respondent has answered 'no' on question 9, then ask about how the decision is made to scale-up existing measures of HIV prevention.

10. In GF-funded programmes, describe, how the needs are determined of the region for coverage with HIV services (whether assessments are conducted, regions consulted, how planning of prevention taking place)

11. How the groups targeted for HIV prevention are determined at the national/regional levels? How are they estimated?

12. Do you know, which populations were the focus for HIV prevention in programmes funded by GF?

13. How were the prevention needs determined for each of sub-populations?

14. Do estimated needs of the projects funded by GF get corrected/amended during the project implementation?

    -yes;

    - no;

    - rarely;

    - never.

15. In which cases the estimated needs are being corrected/amended?

- when a surplus appears of distributed paraphernalia (supplies)[101]/informational materials, etc.;

- when a deficit appears of distributed supplies/informational materials, etc.;

-other cases (describe which).

16. In your oblast/rayon/town, how did the prevention programmes funded by GF, influence the HIV morbidity levels? – in risk groups and in general population

Reduced in risk groups	Reduced in general population
Slightly reduced in risk groups	Slightly reduced in general population
Did not influence in risk groups	Did not influence in general population
Increased in risk groups	Increased in general population
Cannot determine	Cannot determine

17. Which of the following may have reduced the effectiveness of HIV prevention programmes funded by GF?

- insufficient coverage of risk groups;

- weak attendance by clients of SEP (syringe exchange programmes);

- not enough instrumentarium/materials being distributed;

- breaks in supplies of instrumentarium/materials;

- delays in funds transfer

- uneasy access of patients to SEP sites;

- uneasy travel of social workers to SEP sites;

- safety/difficulties of programme staff in implementing prevention activities;

- other (explain what).

18. How was prevention conducted after the onset of GF programmes in populations not targeted by GF-funding?

BLOC OF QUESTIONS ON MULTI-SECTORAL COOPERATION

[101]Needles, syringes, condoms, spirit wipes etc.

19. How effective do you think, is collaboration between state institutions and HIV-service NGOs?
20. How effective was the work of the CCM - National Council on HIV/AIDS-TB in 1 and 6 Rounds? Or Regional CCM? Why do you think so?
21. Can the CCM - National Council – or Regional CMM - influence the implementation of programmes funded by GF? Why do you think so?

BLOC OF QUESTIONS ON THE ROLE OF NGO

22. What role do PR NGOs play in HIV prevention in Ukraine?

23. To whom are the NGOs accountable for HIV prevention activities?

24. Do HIV prevention activities conducted by NGO get monitored? Who is conducting the monitoring of HIV prevention activities?

25. How do you evaluate the role of International HIV/AIDS Alliance as a Principal Recipient of grants in Rounds 1 and 6 of GF? How was it established? Who established it? Does it function as a typically national NGO?

26. The same – of the Network of PLWA? Is it a typical national NGO?

27. How the work of NGOs – as Principal Recipients – is monitored at the country level? What forms does such monitoring take?

BLOC OF QUESTIONS ON EVALUATING THE WORK OF GF AND PERSPECTIVES FOR THE FUTURE

28. Which portion of GF funding was targeted at HIV prevention? In Round 1? In Round 6?
- The largest
- The small part
- Half
- Not sure

28a. In what degree the funding given by GF, corresponded to the country's needs in HIV prevention? Why do you think so?

29. How do you evaluate the effectiveness of resources given by GF to prevention programmes (on a 5-degree scale)?

1 – extremely non-efficient

2 – not very efficiently

3 – average efficiency

4 – efficiently

5 - very efficiently

30. Are the programmes funded by GF different from programmes funded by other donors in HIV/AIDS? How?

31. What are the perspectives of the development of HIV epidemic in Ukraine in future?

32. What are the perspectives of Ukraine receiving new grants from GF? Why do you think so?

QUESTIONS ON GLOBAL FUND ACHIEVEMENTS IN UKRAINE

33. What, to your knowledge, was the main goal of GF programmes in Ukraine?

34. Did the HIV prevention programmes supported by GF achieve the intended goal in Ukraine? Why do you think so?

35. How did the programmes funded by GF, influence the national response to HIV/AIDS epidemic in Ukraine?

BLOC OF QUESTIONS ON DOCUMENTATION OF HIV-PREVENTION SERVICES

1. Which documentation methods are you using to determine the coverage by HIV services?

- Supplied by Principal Recipients (SyrEx, SyrEx Plus, etc.)
- Other
- Own (explain which ones).

2. Do you know other systems of documenting HIV services? Did your organisation have an opportunity to choose among several documentation systems?

3. Is the target correction being conducted during the course of implementing the project?

- Yes

- No
- Rarely
- Never.

3a. How can coverage figures be corrected if the project has started and it is clear that so many clients won't come?

4. In which cases the estimates of coverage are being corrected?

– when a surplus appears of instruments/informational materials etc.

- When the shortage of instruments/informational materials etc. appears,

- Other (explain what).

5. How the unused instrumentarium/supplies is being disposed of?

- utilised;

- thrown into garbage;

- transferred to state medical institutions.

- distributed in advance;

- distributed to one person for more persons;

- other(describe what).

6. Which services do you offer?

- Counseling (including peer to peer), by project staff
- Harm reduction (needle exchange etc.)
- Client support during ARV-therapy, ST.
- Information dissemination (trainings for clients, for staff of projects)
- other

7. How often does the client need to visit the programme to be documented as covered by HIV prevention services?

- No less than once a month
- Once a month
- Twice a month
- Once a week
- Daily
- Give your variant of answer.

8. When entering data into SyrEx, which client is considered "new" and which – "permanent"? How are the permanent clients being documented in database?

9. How does the data system reflect the frequency of how often the client received services?

10. How it is counted how many services did the client receive during one visit?

11. What lies at the base of calculating the coverage indicators?
- The quantity of given paraphernalia (supplies)
- The quantity of distributed information materials
- The number of people who received supplies and informational materials
- The number of times that the person visited the site/community center
- The combination of several or all of the above
- Hard to answer
- Other.

12. Which data about the size of the target population is used to determine the needs of your project?
- Estimates on the region covered by the project (write which ones)
- Own estimates of the organization
- Information supplied by Principal Recipient
- All of the above
- Other.

13. What should, in your opinion, be included into the service that client is receiving during one visit? (not necessarily included now)

14. Is the data collected through SyrEx influencing the possibility of receiving the future funding from GF? How?

15. What is the purpose of using the data on coverage with services and distribution of materials, that are collected by Syrex?
- To prepare PR reports to GF
- To plan further prevention
- To account for money received by sub-recipients
- Other
- Not sure.

16. Is the data collected through SyrEx, reflecting:
- Capacity of NGOs in HIV-service
- Regional/local needs of HIV services
- Real numbers of clients who are permanently covered.

17. Your opinion on using SyrEx.